



# The impact of COVID-19 on long-term care in the Netherlands: the second wave.

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Corrections and comments are welcome at [info@itccovid.org](mailto:info@itccovid.org). This document was last updated on 25 November 2020 and may be subject to revision.

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## Key points

- The Dutch nursing home sector was severely affected by the first coronavirus wave. Although the sector was better prepared for a new outbreak, the second wave has still hit hard. Where in the first wave there was a steep increase in cases and then a rapid decline, in the second wave the number of cases in the long-term care sector has plateaued and it is unclear how long this will continue before cases start falling.
- Protocols, personal protective equipment (PPE) and testing are more accessible than in the first wave.
- The government has not imposed a national nursing home visiting ban, unlike in the first wave. Instead, the government has decided to take a more flexible and regional approach. Nursing homes are given discretionary space to make visiting policies appropriate to their situation.
- Staff shortages, working pressure and staff wellbeing are still a great concern. However, unlike in the first wave, various policies aim to tackle this.
- In the Netherlands, nursing home residents are represented by client councils. However, nursing homes have not consistently included client councils in crisis management.

## 1. COVID-19 in the general population and containment measures

### 1.1. Extent of infections and deaths in the total population

In the Netherlands, after a first wave of COVID-19 infections in Spring, the number of cases decreased by June. As in many other Western countries, the Netherlands faced a second wave of COVID-19 and was unable to suppress the new outbreak (more on this in section 2.2). The regional spread of the virus differs in the second wave from the first one. In the second wave, there has been a great incidence of cases in population centres in the west of the country (Figure 1), whereas the epicentre of the first wave was the south.

The number of COVID-19 cases (Figure 2) reported by the local health authorities illustrates this second wave, but the graph also shows the underreporting of cases in the first wave due to the lack of testing capacity. From the end of August, cases steadily increased before slowly decreasing again after a peak in mid-October. This decline was attributed to the second lockdown announced on October 13 (more on this in section 1.2).

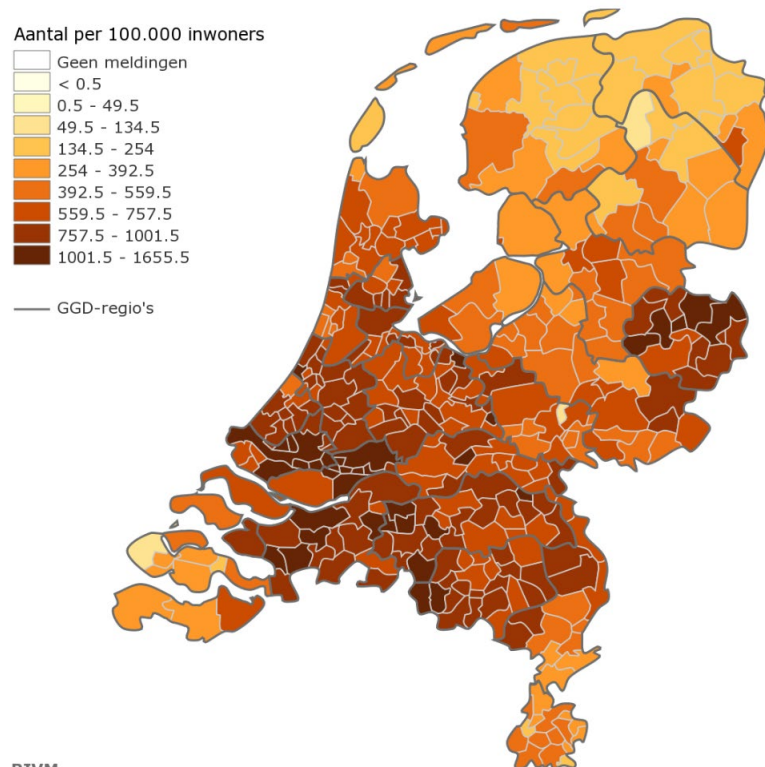
As Figure 3 shows, hospitalisations in the Netherlands increased during this second wave. Although the number of hospital admissions has not reached the peak of the first wave, the Netherlands has been unable to curb the trend as quickly: the number of cases and number of hospital admissions due to COVID-19 have not slowed as quickly as in the first wave.

Excess mortality was high among people aged 80+ during both the first wave (week 12-18) and the second wave (starting around week 38) (Figure 4). People aged 65 and over also experienced higher excess mortality in both the first and second wave, although not to the same extent as in the 80+ age group. (Week 33 shows a short peak of higher excess mortality among people aged 80+ due to a heatwave.)

**Figure 1. Regional variation of COVID-19 patients per 100 000 inhabitants (21 Oct – 3 Nov)**

### COVID-19 patiënten

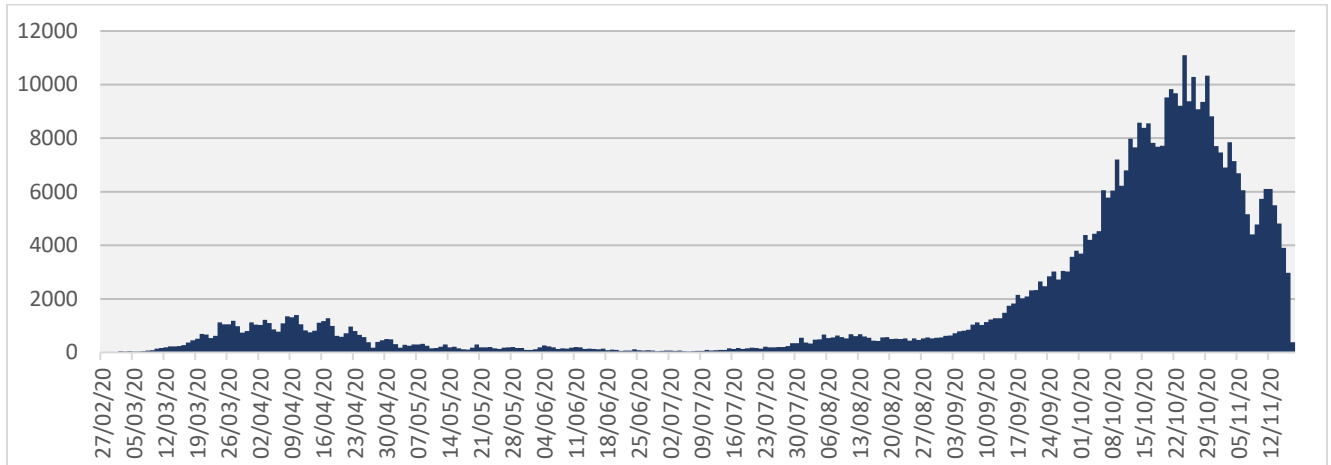
Per gemeente van 21-okt-2020 t/m 03-nov-2020



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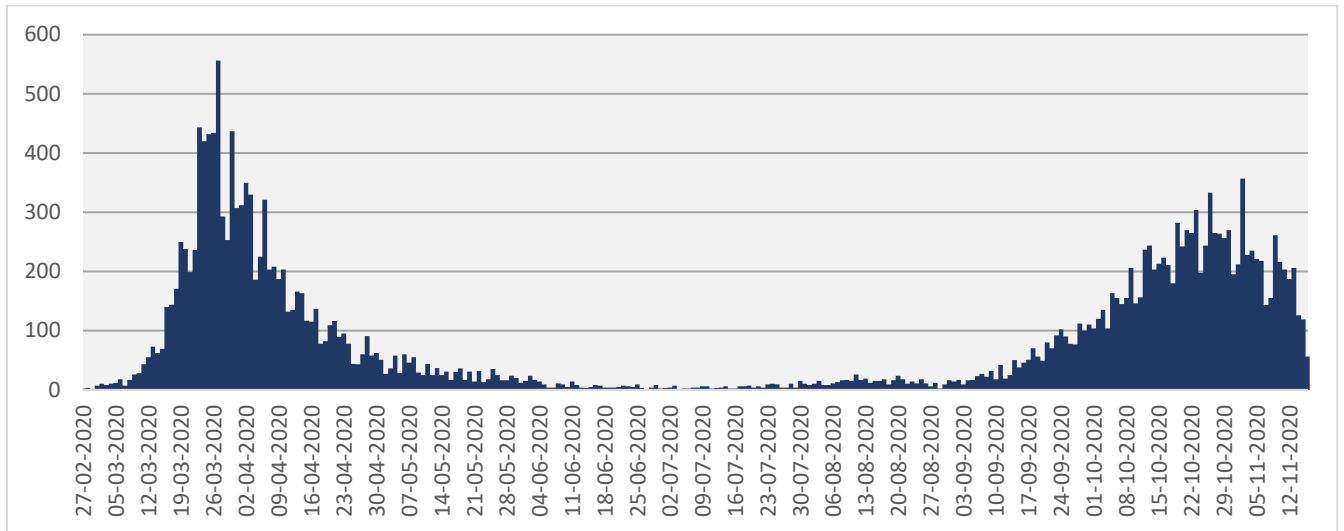
Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 19, 2020 from: <https://www.rivm.nl/coronavirus-covid-19/actueel>

**Figure 2. Number of COVID-19 cases reported by the local health authorities [GGD]**



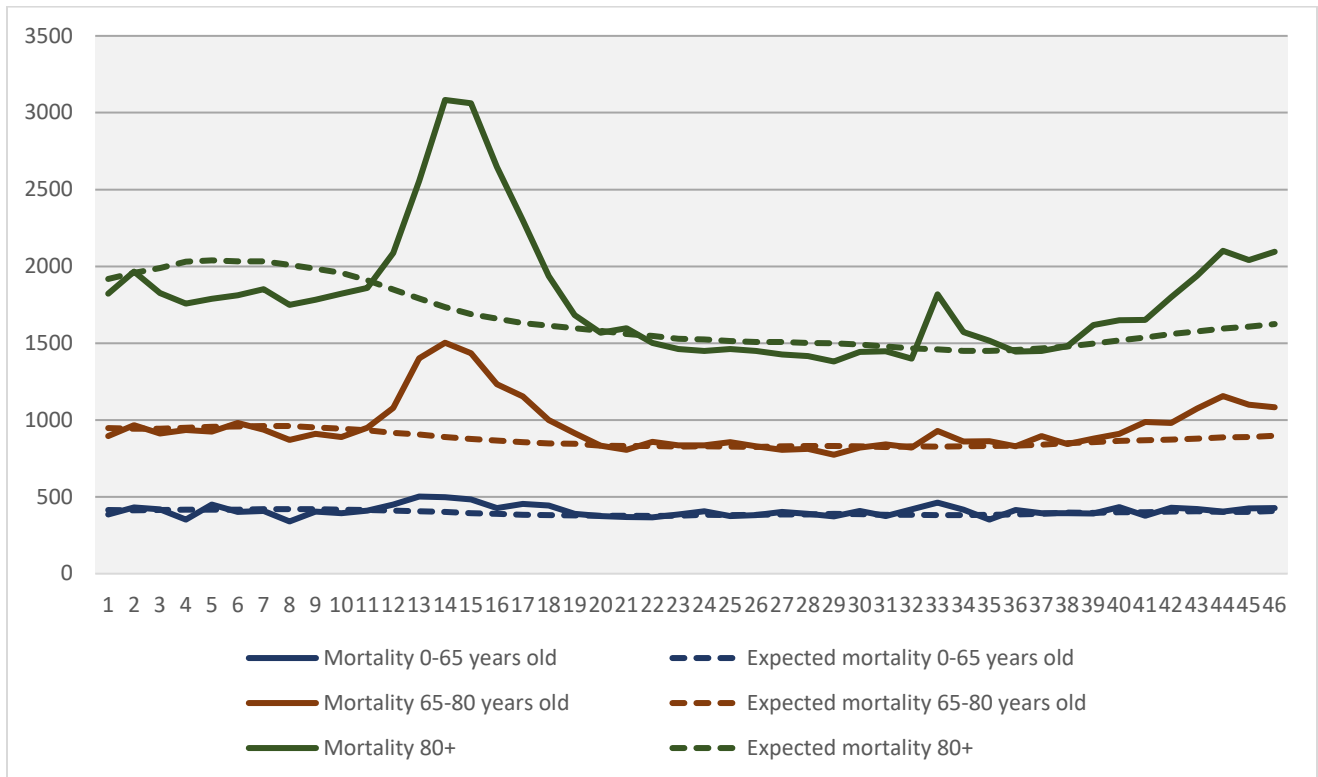
Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 19, 2020 from: <https://www.rivm.nl/coronavirus-covid-19/grafieken>

**Figure 3. Number of COVID-19 patients admitted to hospitals per day reported by the local health authorities [GGD]**



Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 19, 2020 from: <https://www.rivm.nl/coronavirus-covid-19/grafieken>

**Figure 4. Mortality in the overall population by age group per week<sup>a</sup>**



a. Estimated figures have been calculated by CBS and are based on previous years.

Source: Derived from the Statistics Netherlands (CBS). Accessed on Nov 24, 2020 from: <https://www.cbs.nl/nl-nieuws/2020/47/sterfte-in-week-46-nog-steeds-hoger-dan-verwacht>

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

During the first wave of the pandemic, the Netherlands announced an ‘intelligent lockdown’. During the summer – roughly between June and August – the spread of the coronavirus was largely under control and some of the measures were relaxed. However, in September the first signs of the second wave started to show, especially in heavily populated areas in the west of the country (e.g. Rotterdam, The Hague and Amsterdam). To stop this worrisome trend, the Dutch government decided to follow a regional tailored approach, meaning that safety regions (i.e., administrative regions that include multiple large- and small-scale municipalities) were given discretionary space to respond to an outbreak in ways appropriate to their region. For example, Amsterdam and Rotterdam experimented at the start of August with a facemask requirement in crowded places.<sup>1</sup> However, most regions were reluctant to respond in a strict manner and failed to prevent a national outbreak. On 13 October, the Dutch government announced centralised ‘half-lock’ down measures in response to the serious rise of COVID-19 throughout the country.

<sup>1</sup> In comparison with other countries, the Netherlands was slow to impose the use of facemasks in certain circumstances. The reason for this may be that, initially, the Dutch government was not convinced that facemasks worked. They made this argument in various public statements. It took some time to acknowledge the misjudgement and gain the necessary political and social support to change its position.

Some of the measures were similar to those used in the ‘intelligent’ lockdown; others were different:

*Similarities to the ‘intelligent lockdown’:*

- (i) People should keep 1.5 metres distance from each other if they do not live in the same household.
- (ii) People are strongly urged to work from home if possible. Key workers can go to work (e.g. healthcare staff).
- (iii) Cafes, bars, restaurants can provide take-away drinks and meals only.
- (iv) Some facilities in which risk of infection is deemed relatively high (e.g. indoor sports facilities) are closed.
- (v) Public events are still prohibited.
- (vi) People showing potentially COVID-19-related symptoms (i.e. symptoms of a cold, cough, fever) should stay at home (self-quarantine).
- (vii) Essential and non-essential shops remain open.
- (viii) Entertainment venues (e.g., theatres, cinemas) were closed. As of November 17, restrictions were relaxed and these facilities could open if they fulfil the safety requirements [1].
- (ix) Self-quarantine for 10 days is necessary for someone who: (i) has COVID-19 symptoms; (ii) has been in close proximity to someone (less than 1.5 meter for minimal 15 minutes) who has tested positive for COVID-19; (iii) lives together with a roommate that has COVID-19 symptoms and/or is tested positive for COVID-19; or (iv) returned from a high-risk country.

*Differences from the ‘intelligent lockdown’:*

- (i) Visitors are allowed in nursing homes (see section 4.1 how this was decided).
- (ii) People showing potentially COVID-19-related symptoms (i.e. symptoms of a cold, cough, fever) should get tested;
- (x) People can host a maximum number of 3 visitors at home a day. In large (non-home) spaces a maximum of 30 people in one room is allowed;
- (iii) Shops are not allowed to sell alcohol between 20:00 - 7:00 (also referred to as the ‘alcohol clock’);
- (iv) Facilities such as hairdressers remain open.
- (v) Since the beginning of October, the government urgently advises to wearing face coverings in public indoor spaces. They are preparing to make this compulsory this [1].

## **2. Rates of infection and deaths among people who use and provide long-term care**

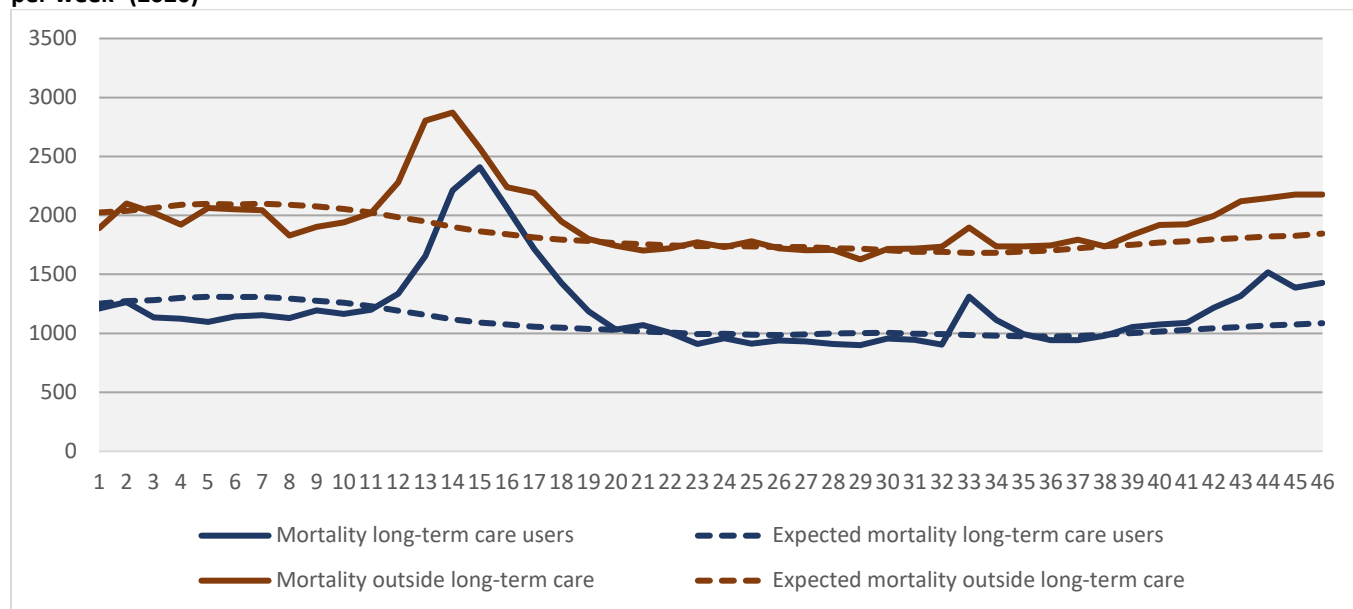
People who use long-term care were severely affected by the first wave, but the second wave has also hit the sector hard (Figure 5). Nursing home residents are overrepresented in the mortality figures in the second wave: approximately 50% of the COVID-19-related deaths are

nursing home residents [2]. In week 46, excess mortality was 31% among people using long-term care services, compared to 18% among the rest of the population [3].

Figure 6 illustrates clearly that the nursing home sector faced a second COVID-19 outbreak in Autumn. The number of cases in the second wave appears to be similar to the first wave, but this figure is misleading since cases were underreported in the first wave due to the lack of testing capacity. Figure 6 also shows that the number of COVID-19-related deaths is slightly lower in the second wave compared to the first wave. The question that arises with these figures is how effectively the healthcare system has cared for COVID-19 patients in the long-term care sector. An empirical study shows that 48% of nursing home residents with COVID-19 passed away within 30 days. In contrast, only 20% of care home residents without COVID-19 passed away [4].

Figure 7 shows that the number of nursing homes with a COVID-19 infection in the second wave has climbed almost to the same levels as during the peak in the first wave. This means that about 35%<sup>2</sup> of the nursing home locations in the Netherlands had a COVID-19 infection at the height of the first wave. The latest data shows that, as of 22 November, 27%<sup>3</sup> of the nursing home locations had infections (Figure 7). Figure 8, shows that the second wave is less intense than the first wave, but it also shows that it seems much more difficult to curb the trend. The duration of the second wave could therefore be longer and possible be more harmful to the sector.

**Figure 5. Excess mortality among long-term care users and outside long-term care (the rest of the population) per week<sup>a</sup> (2020)**



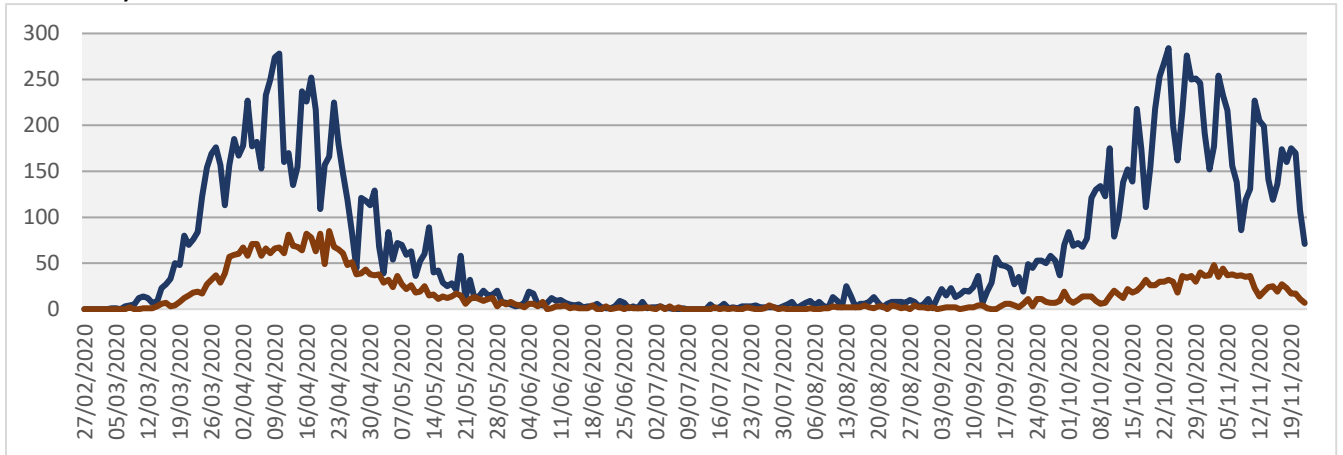
a. Estimated figures have been calculated by CBS and are based on previous years.

Source: Derived from the Statistics Netherlands (CBS). Accessed on Nov 24, 2020 from: <https://www.cbs.nl/nl-nl/nieuws/2020/47/sterfte-in-week-46-nog-steeds-hoger-dan-verwacht>

<sup>2</sup> Registration of the total number of nursing home locations in the Netherlands is far from perfect. In order to include a complete numerator (i.e. number of nursing home locations), we used the well-known client rating website ‘[zorgkaartnederland](http://zorgkaartnederland.nl)’. This website includes 2350 nursing home locations.

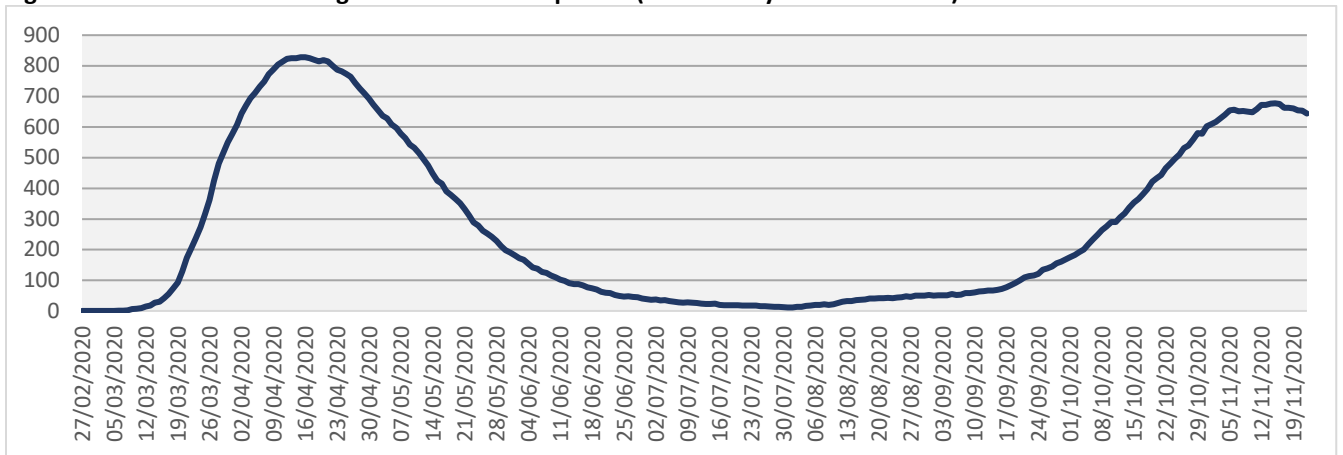
<sup>3</sup> Ibid

**Figure 6: Total COVID-19 cases reported and deceased due to COVID-19 in nursing homes (27 February – 22 November)**



Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 24, 2020 from: <https://data.rivm.nl/geonetwork/srv/dut/catalog.search#/metadata/0179dd26-7bf6-4021-857f-8623aaf8e73a?tab=relations>

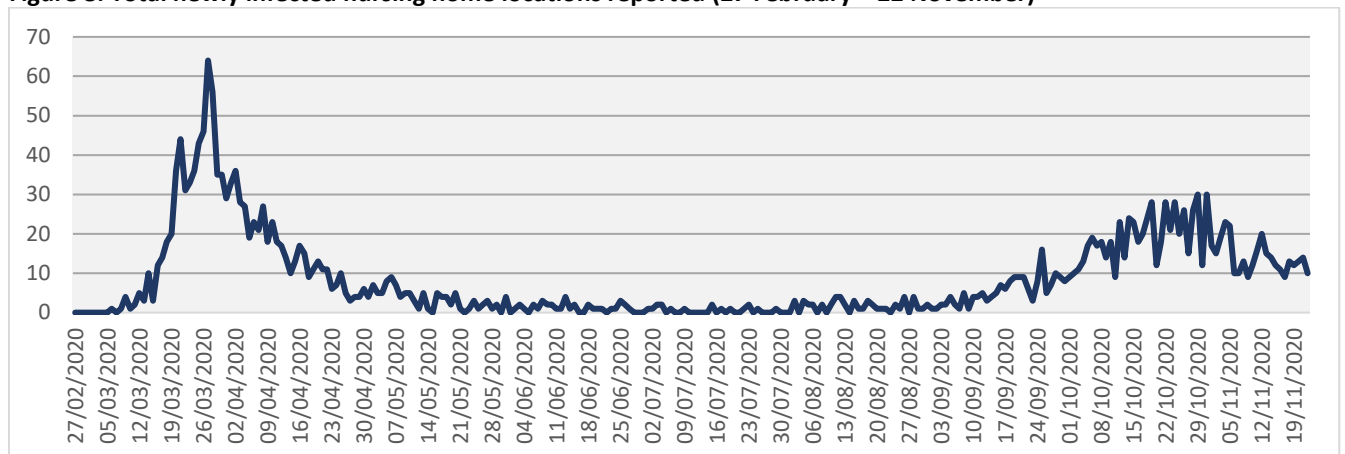
**Figure 7: Total infected nursing home locations reported (27 February – 22 November)**



Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 24, 2020 from: <https://data.rivm.nl/geonetwork/srv/dut/catalog.search#/metadata/0179dd26-7bf6-4021-857f-8623aaf8e73a?tab=relations>



**Figure 8: Total newly infected nursing home locations reported (27 February – 22 November)**



Source: Derived from the National Institute for Public Health and the Environment (RIVM). Accessed on Nov 24, 2020 from: <https://data.rivm.nl/geonetwork/srv/dut/catalog.search#/metadata/0179dd26-7bf6-4021-857f-8623aaf8e73a?tab=relations>

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

The Netherlands is one of the highest spenders on publicly funded long-term care: Dutch long-term care costs are more than double the EU average. 27% of total healthcare spending goes to long-term care [5]. In order to control rising long-term care costs, the Dutch long-term care system was reformed in 2015. The aim of the reform, besides cost saving, was to promote and support independent living. This reform initiated a shift from residential to a non-residential care settings and a normative reorientation towards, where possible, individual and social responsibility [6].

The long-term care system is now divided between three Acts: the Long-term Care Act (Wet Langdurige Zorg: Wlz), the Social Support Act (Wet maatschappelijke ondersteuning: Wmo) and the Health Insurance Act.

The Long-term Care Act (Wlz) covers the most vulnerable people. These are people who require permanent supervision or 24-hour care nearby. This type of care provides a wide set of services including residential care. Care is both needs and means-tested. Clients are identified by the Care Assessment Centre [Centrum indicatiestelling zorg: CIZ], which is a public independent governmental body that decides if a client needs Wlz-care. The regional care offices [‘zorgkantoren’] are linked to the largest healthcare insurer in a particular geographical area [‘zorgkantorregio’s’], and purchase long-term care for the clients in their region from nursing homes and other long-term care organisations [6]. The long-term care act is financed through a compulsory health insurance policy in combination with co-payments. The latter is slightly under ten percent and illustrates that such co-payments are comparatively limited [7]. The level of co-payment is based on income and wealth. Recently, national policy programs have allocated financial resources to the regional care offices to financially support cooperation between nursing homes as part of the aimed-for ‘regionalisation’ of healthcare [8]. While healthcare policy

increasingly encourages cooperation on regional level, recent debates discuss what to organise on which scale [9]

The Social Support Act underscores individual and social responsibility. The Social Support Act is designed for those that need additional help and assistance but do not require care that falls under the Long-term Care Act. The Social Support Act provides assistance programs – for example meal services, funding to adapt houses or transport services. The act also arranges community programs, such as day care. This act has been decentralised. Municipalities have the discretionary power to carry out the needs assessment procedure, also known as the kitchen-table-conversations [‘keukentafelgesprek’]. During this assessment, the needs and the social position of the care-seeker are taken into account, for example whether they already have informal caregivers. The Social Support Act is funded by taxes and co-payments: municipalities receive state budgets and co-payments are income and wealth dependent.

Under the Health Insurance Act, the role of health care insurers in long-term care has expanded since the long-term care reform in 2015. Health insurers cover a part of long-term care related to direct health or limitations that people have in their activities of daily living. These activities are home and community nursing [wijkverpleegkundige] and personal care. The Health Insurance Act is financed based upon solidarity through a compulsory health insurance policy. No co-payments apply for these LTC activities in the Health Insurance Act.

People who fall under the Long-term Care Act, Health Insurance Act or the Social Support Act can, instead of care in-kind, also opt for a personal budget [persoonsgebonden budget: pgb]. Persons with a personal budget can then arrange their own care or support according to their preferences. The decision whether the personal budget is granted rests with the regional care offices (Long-term Care Act: WLz), with the municipalities (The Social Support Act: Wmo) or the insurers (Health Insurance Act: Zvw).

In 2019, one of the main concerns for the long-term care sector was the sharp increase in the number of people seeking long-term care and the growing waiting list to access nursing homes. The number of people seeking care in long-term care facilities has grown by 7% in 2019 compared to the previous year [10].

Democratic accountability in the Dutch healthcare system is relatively well organised by law. The act ‘WMCZ’ requires all healthcare organisations to have a client council that serves clients’ interests [11]. Last July 1<sup>st</sup>, this act was replaced by the act ‘WMCZ 2018’. The act contains rights for client councils to truly participate in organisational decisions regarding matters that influence the clients’ daily lives [12]. Client councils have the right to consent to these decisions. Besides, client councils have the right to provide solicited and unsolicited advice.

In order to get a better understanding of the Dutch long-term care system, Table 1 outlines several key statistics.

**Table 1. Key statistics on the long-term care system in the Netherlands**

Number of older persons (65+) (2016)	3 million [13]
Share of population 65+ (2017)	18.5 [5]
Percentage of older persons (85+) using long-term care (Wlz) (2016)	33% [13]
Percentage of older persons (85+) using care support (Wmo) (2016)	30% [13]
Total healthcare costs spent on nursing home care (2016)	11 billion [13]
Percentage of total healthcare spending on long-term care (2017)	27% [5]
Life expectancy at age 65 (2017)	20 years [5]
Ownership structure of nursing homes (2019)	87.8% non-profit and 12.2% for-profit [14]

## 4. Long-term care policy and practice measures to contain and mitigate the impact of COVID-19

### 4.1. Whole sector measures

Similar to the first wave (see our report in May [15]), the Dutch response has focused on slowing down the spread of the virus during the second wave. The aim was to avoid a demand peak that would significantly strain the resources of the healthcare system. The government has also sought to protect older people and those with poor health. Unlike during the first wave, the protective ring around long-term care facilities now consists of better access to PPE, protocols and higher testing capacity (although testing remains an issue), and does not require facilities to close their doors completely to visitors to keep the virus out [16].

The government response can still be described as, on the one hand, imposing centralised measures and, on the other hand, relaxing traditional rules and standards to give long-term care professionals discretionary power to make certain decisions [17]. The government has given nursing homes more discretionary space to respond to the second outbreak compared to the first, enabling a more tailored response. In a display of democratic accountability, the government responded to bottom-up pressures from various long-term care stakeholders (including academic experts, executives and directors), who called on the government to keep nursing homes open for visitors during a second wave [18].

Within long-term care facilities, the trend towards more democratic accountability during the second wave is seen at a meso-level. At the beginning of the COVID-19 crisis, long-term care facilities installed crisis management teams to make quick top-down policy decisions within their organisations [19]. Now, during the second wave, some crisis management teams are giving back some professional accountability to location management or individual professionals [20].

During the first wave, client councils were unable to participate in crisis management due to limitations on holding meetings and, sometimes, due to other priorities of crisis management teams [21]. However, on 1 July, the act ‘WMCZ 2018’ was introduced, which spells out the rights of client councils to participate in organisational policymaking (see section 3). After the introduction of this policy, participation of client councils in crisis management slowly started to increase, but remains insufficient in numerous organisations and requires attention [19].

The government has expressed its gratitude to healthcare personnel for their hard work during the crisis by granting them a fixed individual one-time net bonus of €1,000 [22]. Currently there is fierce discussion within parliament over whether to pay healthcare personnel more, not only during the pandemic, but on an ongoing basis. The government has put its foot down and argues that the system already has an automatic structural adjustment scheme [23].

#### **Box 1. Financial resilience nursing home sector**

Even though the financial position of the nursing home sector prior to the crisis was relatively strong [24], the sector’s financial resilience deserves attention. The sector faces falling demand due to COVID-19: (i) individuals in need of care are postponing their entry into a nursing home facility; (ii) and because of the higher excess mortality in the sector (see Figure 5), the number of residents has fallen. The sector is simultaneously confronted with higher costs because of the costs to purchase additional material (e.g. PPE, plastic screens) and additional personnel costs (employing more personnel and/or paying for expensive agency personnel).

The government responded to this concern and announced that additional costs as a result of COVID-19 incurred from 1 March 2020 are eligible for reimbursement [25-27]. This concerns additional personnel and material costs during this pandemic [26]. Nursing homes and home care providers may also request a compensation for their revenue losses to prevent financial liquidity problems and ensure continuity of long-term care [27]. At the time of writing, the government is discussing whether to extend these measures until 1 January 2022 [1].

#### **4.1.1. Allocation of PPE based on risk of infection**

##### *4.1.1.1. Accessibility*

When the COVID-19 pandemic first broke out in spring 2020, it was accompanied by a worldwide shortage in PPE (personal protective equipment). The situation has significantly changed for the better in the second wave – PPE are now better accessible. Nursing homes express that they are prepared for the second COVID-19 wave [16]. The availability of protocols and sufficient PPEs contributes to this statement [25].

##### *4.1.1.2. Allocation*

The Ministry of Health, Welfare and Sport partnered with hospitals, suppliers and producers in late March to manage the distribution of medical materials to combat the epidemic. The consortium acts like a centralised (non-profit) purchaser [28]. However, establishing a fair and efficient allocation system for PPE has proven to be difficult in the past. The nursing home sector

in particular had raised the alarm about supply shortages as early as mid-March [29]. On 13 April, the Dutch government launched a new centralised allocation mechanism for PPE in order to improve its distribution [30]. At first, the focus was very much on acute care, but now the allocation mechanism also applies to long-term care facilities. The allocation mechanism initially only applied to face masks but is being expanded gradually to include other PPE [31].

The distribution of PPE has improved since the first wave, and the national consortium purchases and distributes PPE to places where they are most needed [32].

#### *4.1.1.3. Use*

PPE is used when caring for someone that is (expected to be) positive for COVID-19. Additionally, facemasks are used as preventive measures [1]. Care providers can decide when to use facemasks based on their own professional experience [1]. Since the beginning of October, the government urgently advises to wear facemasks in public indoor spaces. They are preparing to legally obligate this [1]. However, some people are unable to wear a facemask due to disability or chronic illness. They are therefore excluded from this governmental advice and will also be excluded from a future obligation [1].

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

There were already staff shortages in the long-term care sector prior to the pandemic, but COVID-19 worsened the situation. In our report published in May [15], we expressed our concern about staff shortages and mental health issues among staff members. This has not changed much since then, and it may even have worsened. The Minister of Health, Welfare and Sport stated on October 27 that the perceived work pressure of employees in most nursing homes has not decreased and absenteeism has increased [25].

Staff shortages can be the result of a corona infection or the need to self-quarantine. When there are severe staff shortages, staff members with COVID-19 related symptoms or who live with housemates with COVID-19, can still go to work, despite guidelines indicating otherwise [19, 33]. Staff members are worried about their own health and about infecting others. Many organisations offer mental support, for example by organising campaigns, webinars and consultation of social workers or psychologists.

The medical specialist care sector has scaled down elective care during the pandemic because of the staffing difficulties during the pandemic. In the nursing home sector, however, scaling down is much more difficult because people live in long-term care facilities and their care cannot easily be put on hold. Yet, at the time of writing, the long-term care sector is also preparing to scale down some of its care during the second lockdown because of pressing staff shortages [34]. Different stakeholders published a guideline on how long-term care providers can make these tough decisions responsibly [35].

Since the first wave, long-term care organisations have tried to solve the pressing shortages in care workers by attracting, for example, flex workers and by reorganising personnel within their long-term care organisation. However, personnel shortages still pose a pressing challenge for stakeholders and the government. Therefore, various promising developments were initiated to tackle this pertinent issue:

- A large IT-platform was launched to match healthcare personnel with healthcare providers in (great) need of help, carrying the title 'Extra Hands for Healthcare' ([www.extrahandenvoorde zorg.nl](http://www.extrahandenvoorde zorg.nl)). This platform is for the entire healthcare system, including long-term care. Healthcare providers indicate what kind of help and skill-set they need and this platform will try to match supply and demand. This platform has been actively used, but this initiative is also encountering barriers such as HR bureaucracy [25]. A designated team tries to help lift the barriers and facilitate the smooth operation of this platform [25]. This initiative is a collaboration between stakeholder organisations and the Ministry of Health, Welfare and Sport.
- Healthcare personnel that left the healthcare sector has been requested to return to the sector. A campaign 'Duty Calls' aspires to help employers to give their employees with a healthcare background the possibility to help out in this second wave [25].
- A large initiative provides quick training (one week) to those without any healthcare background or limited background – labelled as the 'National Healthcare Class'. For example, former KLM personnel have been retrained to work in the healthcare sector.<sup>4</sup> These people are then matched via the 'Extra Hands For Healthcare' platform. Up until now, 120 people per week were trained [25]. The aim is to scale this up.
- Students with a post-secondary vocational education and higher vocational education are requested to postpone their internships and work for the healthcare sector. While still being paid, they gain relevant practical experience.
- Various brochures are published and used to provide psychological support [33]. The aim is to inform and protect current staff members for the impact of the crisis and the increase in workload.

## 4.2. Care coordination issues

### 4.2.1. Hospital discharges to the community

The Dutch Federation of Medical Specialists issued a guideline on April 10 for hospital discharge of patients who have been on the Intensive Care Unit [36]. Since then other guidelines have been issued [37], but they generally state the following:

- Patients with mild complaints can go home, should be supported by their General Practitioner (GP) and receive home care if necessary.
- Patients who cannot go home, but that do not need intensive care, will be discharged to a care institution where patients stay for a limited time and receive, if needed, 24-hour nursing care. A transfer letter must be written by the medical specialists (who has a coordinating role) in which the current level of contagiousness is described, as well as the need for other care services, such as physiotherapy or special dietary requirements [37].
- Frail patients/patients with multi-morbidity involving limitations in physical or cognitive functioning should receive geriatric rehabilitation care. The guidelines state that regional

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<sup>4</sup> Although, only a few former KLM employees actually decided to go work in the long-term care sector. <https://www.zorgvisie.nl/klm-stewardessen-willen-geen-billen-wassen-in-de-ouderenzorg/>

agreements between geriatric rehabilitation centres and more specialised medical rehabilitation centres should be made [37].

- Patients who were high-functioning before their COVID-19 infection should get specialised rehabilitation care, either inpatient (hospital rehabilitation department or a rehabilitation centre) or outpatient. Guidelines mention the use of a post intensive care toolkit ('REhabilitation After Critical illness and Hospital discharge, REACH) for rehabilitation and primary care workers [37].

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

It is unusual for nursing home residents to be transferred to the hospital due to suspected or confirmed COVID-19. The standard is to treat frail (older) people in their existing home setting as much as possible. Despite this standard, the Dutch associations of geriatricians and physicians who are specialised in caring for people with mental disabilities issued a guideline for the transfer (or admission) of patients in nursing homes. This includes admission from the patients' home to a nursing home or the transfer to another care institution. The recent updated advice (8 September) has a strong preventive character as it aims to minimise the risk of infections [38].

Due to visiting restrictions in many nursing homes, many people postponed or refused to be admitted to a nursing home. Besides, some nursing homes or departments with COVID-19 infections temporarily did not admit new clients. These two phenomena led to empty beds in nursing homes. One of the responses that the Netherlands took to address these empty beds is to help hospitals in need of additional beds [25] (both patients with and without COVID-19). This could be a win-win situation: the nursing homes are reimbursed to provide these extra beds and it may relieve the pressure on hospitals. However, nursing homes sometimes feel pressured by hospitals to do so.

#### **Box 2. Nursing homes' participation in (sub)regional networks**

The aim has been to strengthen regionalisation of healthcare [8, 39]. Nursing homes are increasingly addressed as part of a regional network in which healthcare organisations (hospitals, primary- and psychiatric care facilities, municipalities, etc.) organise care for a population in a specific geographical area ('the region'). During the second wave, the collaboration between nursing homes and hospitals strengthened; either through (in)formal consultations or already existing network-oriented forms within the (sub)region. Moreover, nursing homes are included in administrative acute care networks with hospitals (so-called 'RONAZ') in various regions throughout the country, indicating their growing importance in regional networks.

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

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

#### *4.3.1.1. Visiting rules for nursing homes*

One of the most important lessons of the first COVID-19 wave was that a ban on visitors was undesirable because of its negative impact on the well-being of residents, relatives and employees [18, 25, 40]. The government acknowledged this lesson in the ‘Temporary Measures Act COVID-19’, passed in October [41]. The law specifies that, at the very least, a client must always be able to receive a visit from one family member or next of kin [42]. The law also stipulates that the responsibility for safety of nursing homes rests primarily with the healthcare providers themselves. Thus, as mentioned earlier, long-term care providers have more discretionary space to decide which measures they take with regard to visiting rules and which measures they take to prevent the spread of the virus [25]. The idea is that the individual homes can best assess how visits can be made in a safe manner, and write visiting policies accordingly – one that is appropriate to the situation in their locality [43]. As a result, a variety of visiting rules exist within the nursing home sector [25].

There are several commonalities between the visiting policies. (i) Decisions within nursing home organisations are more often made locally, by location management, rather than by their headquarters [20]. (ii) Nursing home residents, their relatives and staff members should be included in the decision-making process of their respective nursing homes when drafting visiting policies [43]. (iii) Nursing home visitors are often obliged to wear facemasks [19]. (iv) Many nursing homes request that visitors register their visit and that they provide their contact details for an effective track and trace system.

A centralised healthcare inspectorate does monitor how the nursing homes exercise their ‘freedom’ and may correct them if deemed insufficient or, interestingly, disproportionately restrictive [44].

#### *4.3.1.2. Activities*

Currently, the regular activities in most nursing homes have restarted as much as possible, although sometimes in adaptive form to maintain to population level measures (such as 1.5m. distance). Residents can undertake community and welfare-oriented activities as well [25].

#### *4.3.1.3. Testing policies*

Before 6 April, testing was only available for the first two cases in one long-term care organisation. If two residents had already tested positive, other clients with symptoms should be treated as positive [30]. Since 6 April, all nursing home residents who are suspected of being infected with COVID-19 can be tested [30]. As of 1 June, everyone in The Netherlands will be able to get tested for COVID-19 by their local health authority if they experience COVID-19 related symptoms, without referral from a healthcare professional [45]. New testing policy now allows



all healthcare staff to get tested with priority by the local health authorities, some of the results are available on the same day of testing. This includes long-term care workers [46].

Currently, testing remains logistically challenging as test capacities are sometimes insufficient. For example, there are difficulties with how to request tests (sometimes people have to travel quite a bit to get a free timeslot at a local health authority) and with the prompt communication of test results. Thus, several nursing home organisations maintain private test capacities [19].

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

Since 6 April 2020, all nursing home residents who are suspected of being infected with COVID-19 can be tested. They can also access testing quicker than other people can to control the spread of the virus in the facility. Verenso, the association of geriatricians, and the association of physicians for people with intellectual disabilities (NVAVG) issued a guideline that all residents with (suspected) COVID-19 or residents that possibly have been exposed to the virus should be put in quarantine and cared for in isolation [38]. This can be individual isolation or within a cohort. Depending on regional infection rates, quarantine is recommended for newly admitted clients [38].

In general, nursing homes have access to much more and better information about how to control the spread in the second wave than in the first wave. There are bottom-up initiatives to guide and advise nursing homes to prevent a large outbreak in the sector. For example, an already existing publicly financed program 'Dignity and Pride on Location (*Waardigheid en Trots op locatie*)' distributed a 'roadmap' that allows healthcare providers to check whether they have prepared themselves for a new pandemic. For example, this program provides an Excel sheet that include a stepwise checklist for how nursing homes can respond effectively to the pandemic [47].

### **4.4. Community-based care**

#### **4.4.1. Measures to prevent spread of COVID-19 infection**

The measures in the second wave are in slight contrast to the measures that have been taken in Spring. For those individuals who could fall back on their own social network, non-essential homecare activities were postponed in the first wave [48]. The approach in the second wave is different. Care at home or support may not be reduced without consulting the care recipients. However, sometimes less care and support can be provided temporarily when there is, for instance, lack of staff [25]. Clients are sometimes less satisfied with the continuity and/or the alternatives offered. The aim is that the client (and his/her supervisor, if applicable) and the provider continue to discuss what the client's personal situation is and what day activities are possible within the current situation [25].

Large efforts have been made to continue daytime activities as much as possible and some of those activities have moved to digital day care [25]. Good practices of digital day care are shared on a government website [49]. The government has, due to this crisis, increased their subsidies to develop e-health applications, and invested especially in those applications that support vulnerable people who still at home [25].

Vilans, the national Centre of Expertise for long-term care in the Netherlands, issued a guideline for community care organisations. They should create crisis teams and publish emergency plans. These crisis teams should, for example, monitor clients and their personnel closely for COVID-19 symptoms and keep a close eye on the developments in the region [50].

Although daytime activities have not really been scaled down during the second wave, there are additional challenges [25]:

- Difficulties to keep the 1.5 meters distance;
- Staff shortages (i.e. professionals and volunteers) due to having to work in smaller groups and the increasing absenteeism due to corona (e.g. quarantine, pending test);
- Conducting daytime activities in smaller groups requires more locations (or more availabilities of locations), however, there are insufficient suitable locations;
- Uncertainty about what kind of additional cost are reimbursed;
- Wariness among care recipients as well as volunteers to visit daytime activities;
- The waiting times have increased again.

#### **4.4.2. Testing**

As of 1 June, everyone in The Netherlands will be able to get tested for COVID-19 if they believe they have relevant symptoms, without referral from a healthcare professional [45]. (See section 4.3.1.) This is very different from the situation in spring when testing capacity was limited and at one stage only vulnerable people (i.e. 70+ years of age and/or relevant underlying conditions) were eligible to get tested, but only when it was relevant for their care or treatment [51].

#### **4.5. Impact on informal caregivers and measures to support them**

On 16 April, the Dutch government issued guidelines for informal caregivers. These guidelines include advice on hygiene standards and guidelines on how a caregiver should act if the person they provide care to develops symptoms of COVID-19 [52].

As of 19 May, free PPE is available for informal caregivers of vulnerable people (70+ years of age and/or chronic conditions). Furthermore, all informal caregivers with symptoms of COVID-19 can get tested as of 18 May [53]. If the caregiver has symptoms, they have to go in quarantine and care is replaced by a professional caregiver [52].

Many informal carers experience more pressure and distress than before the COVID-19 crisis [54]. Every municipality has set up support desks for informal caregivers. They can advise informal caregivers where to get help or support [55]. A healthcare professional may be appointed to support informal caregivers (e.g. community nurse) [52].

When the person receiving care or the informal caregiver catches the virus, and care at home is no longer possible, the guideline states that the general practitioner (GP) should immediately be informed. The guidelines also advise that GPs play an important role in supporting the informal caregiver. GPs should closely monitor those who are homebound and frail, and should act like a case-manager when they develop COVID-19 symptoms [52].

## 5. Lessons learnt so far

### 5.1. Short-term calls for action

In response to the second wave, the Netherlands have addressed most of the short-term calls for action mentioned in our last report [15]. However, there are still several calls for action that need to be addressed based on our findings in this report.

The government and the long-term care stakeholders should:

- Continue to tackle staff shortages and reduce working pressure on long-term care staff during the pandemic. These efforts are crucial to prevent a serious erosion of quality of care and will counteract serious mental health issues among healthcare personnel;
- Optimise testing infrastructures, particularly in more remote areas;
- Stimulate and support democratic accountability for care recipients and their relatives in decision-making processes related to COVID-19 measures in long-term care;
- Further strengthen collaboration between nursing homes and hospitals during the pandemic. Nursing homes can help hospitals by offering places to hospital patients transfers (COVID-19 and non-COVID-19). This may relieve pressure on hospitals and, in addition, nursing homes could improve their financial situation. It is important that the nursing home sector is given sufficient support to play this new role, not only in financial terms, but also with regards to ensuring that this is collaboration can be done in a safe manner.
- Even though data has greatly improved since the early stages of the first outbreak, there is still a lack of transparency. The issue now is that some of the data is not shared publicly. The most pressing example is that data on nursing home level is lacking, which will, and is already, hampering future research on this topic. This is unfortunate because it is essential to further develop our understanding of the outbreak in the long-term care sector which could help improve our response in the future.

### 5.2. Longer term policy implications

Several long-term lessons can be learned from the developments related to COVID-19 and its impact on the long-term care sector. Based on the findings of our own report and views from experts in the long-term care field, we distil seven important lessons:

- 1) The long-term care sector has been overshadowed by the acute care sector during the first COVID-19 outbreak. As one of the representatives of the association of long-term care organisations (ActiZ) in the Netherland put it in an article published on 22 May: “care for elderly people has continuously received too little attention from National Institute for Public Health and Environment” [Ouderenzorg had steeds onvoldoende aandacht bij het RIVM] [56]. During epidemic crises, it is important to pay specific attention to the long-term care sector in the earliest stages. This has indeed improved in the second wave: the voice of the long-term care sector is much better represented in, for example,

advisory groups to the government. However, stakeholders still raise the issue that not enough attention has been given to the nursing home sector in this second crisis [57].

- 2) This epidemic crisis amplifies the already existing shortages of care professionals, especially in long-term care. This crisis provides a window of opportunity to improve the way we value care professionals, both in monetary terms as well as in their working conditions.
- 3) This crisis may also be a window of opportunity for investment in e-health technologies [58]. E-health may offer opportunities to alleviate staff shortages. However, little is known how this impacts current working practices of geriatricians, nurses or carers, especially during a pandemic.
- 4) Long-term care facilities face significant financial losses due to high vacancy rates and higher expenditures associated with hiring additional personnel and installing extra health and safety measures. If the nursing home sector does not receive adequate financial compensation for these losses, a large number of nursing homes may suffer financial distress in the near future. We need to keep a watchful eye on whether the financial support that the government has granted to the nursing home sector is enough to keep it afloat.
- 5) Although somewhat less frequently mentioned, pressure on informal caregivers has increased due to the COVID-19 crisis. The Netherlands Institute for Social Research argues that this crisis and the lock-down shows the cracks in our healthcare system [59], leaving vulnerable people without social support and informal caregivers overburdened. This sparks the question whether we should re-evaluate the long-term care reform. The aim of this reform was to promote and support independent living. The Netherlands Institute for Social Research proposes to look into an intermediate form between living at home and living in a nursing home [59, 60].
- 6) Nursing homes' participation in (sub)regional networks is considered as increasingly relevant during the COVID-19 crisis to distribute recovering patients in closely cooperation with hospitals and primary care facilities. Besides the (in)formal consultations in times of crises, nursing homes' role and involvement in a more cooperative led and networked organised healthcare system seems highly desirable.
- 7) Reflecting on the pandemic crisis so far taught us is that democratic representation of patients and their relatives in local, regional or even national decision making regarding COVID-19 measures is somewhat unspoken. Yet, against the backdrop to enhance regionalisation of healthcare, more attention to the perspectives of patients and their relatives, and to what extent these are echoed in developing long-term policy, is needed.

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