**Nursing homes and COVID-19: we can and should do better**

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The COVID-19 pandemic is providing us with many painful lessons particularly the vulnerability of individuals living with chronic conditions and the need for preparedness, coordination, and monitoring. Long-term care facilities, including nursing homes, skilled nursing facilities, and assisted living facilities, provide care for some of the most vulnerable populations in society, including older people and those with chronic medical conditions. In the United Kingdom, there are about 17,000 people living in nursing and residential care homes and 200,000 Australians live or stay in residential aged care on any given day. In the United States (US), more than 1.3 million individuals live in 15,600 nursing home facilities. Washington State in the US signaled the beginning of the COVID-19 pandemic in the US, where there were 35 deaths in a single King County facility. The numbers of positive cases and deaths in nursing homes from COVID-19 continue to rise in other residential facilities across the world (Adalja *et al.* 2020) (Bedford *et al.* 2020).

Nursing homes have been documented as having high transmission rates for infectious diseases for a range of reasons including crowding, sharing of bathroom facilities and gathering in common areas as well as low preparedness for infection control. Recognizing the high risk associated with these facilities, the Centers for Disease Control in the US has released interim guidance for the prevention and control of COVID-19 (Centers for Disease Control and Prevention; 2020). Staffing shortages and frequent staff turnover, high resident-to-staff ratios, supply shortages, and inadequate infection prevention and control measures are well documented in these settings but solutions are less apparent (Dorritie *et al.* 2020). In recent times, there has been a focus on admissions to acute care from nursing homes because of lack of resources to manage clinical deterioration (Considine *et al.* 2019). Strategies have been trialed to augment nursing care, such as nurse practitioners providing consultation, but these are not systemic solutions; we need to be strategic and data driven in health workforce planning.

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A global pandemic increases the salience of ensuring safe environments for care of the most vulnerable (Bedford *et al.* 2020). Over recent decades, the complexity of management has increased in long term facilities including the care of individuals with tracheostomies and complex wounds. Although the word 'nursing' is in the titles of these institutions and their regulations, this can lead to unrealistic expectations for the level of care provided. The numbers of registered nurses (RNs) likely to be found in long-term facilities are low with licensed practical nurses and certified nursing assistant providing the majority of care. These health care workers are valuable members of the healthcare team (Laxer *et al.* 2016), but they do not have the skills, resources, training and scope of practice of the RN in dealing with the challenges of individuals requiring complex care, particularly in the context of a pandemic. Although the role of the RN is specified in guidelines, with facilities in the US required to have at least one on site for at least eight hours every day, these guidelines are commonly not adhered to (Geng *et al.* 2019) and numbers are likely inadequate to meet needs. Internationally the quality of patient outcomes has been challenged and often attributed to staffing or resources (Andersson *et al.* 2018) (Spilsbury *et al.* 2011).

A registered nurse is an individual who has graduated from an approved school of nursing and has passed a national licensing exam. The RN undertakes physical assessment and comprehensive health evaluation before making critical decisions; provides counseling and education; administers medications and non-pharmacological interventions; and engages in care coordination, while collaborating with other health care professionals. In many countries, there has been consistent advocacy to ensure a minimum level of baccalaureate education for entry to practice and there have been several influential studies demonstrating a positive correlation between level of education and patient outcomes in acute care but the data in long-term facilities is not available (Kutney-Lee *et al.* 2013) (National Academies of Medicine. 2011).

In the United States, Kaiser Health News reports large variability based on the availability of RN staffing (Kaiser Health News. 2019). Geng and colleagues studied a number of facilities and found that greater than half of the facilities met the expected staffing level less than 20% of the time. These staffing issues were most evident for RNs, where 91% of the facilities met guidelines less than 60% of the time (Geng *et al.* 2019).

A welcome advance in the context of COVID-19 has been the expansion of telehealth and telemedicine services to nursing homes, which may provide opportunities to improve care in the longer term. Recent events have demonstrated the need for well-funded, responsive and efficient workforce models that protect

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both residents and health care workers.  This is a delicate dance, as we need to provide adequate clinical care without excessive medicalization of what is an individuals' home.  Nevertheless, events over prior weeks that continue to unfold challenge us and for many of us it is not appropriate in a just and civilized society to deny our most vulnerable access to quality care.     Many may argue that this is an aberration in the context of a pandemic but data over many decades tell us, this is not the case.  The COVID-19 pandemic has taught us failing to address staffing and care models in nursing homes and skilled nursing facilities is in fact a public health issue. There will be many valuable examples learned from the COVID-19 pandemic and we hope that the importance of infection control practices and the role of RNs in residential facilities is not a lost lesson.

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