



Care Homes- Covid-19

ACCESS TO MEDICAL CARE

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Access to Medical Treatment in Care Homes

Introduction

Covid-19 is creating unique and vexing issues for those involved in our care homes.

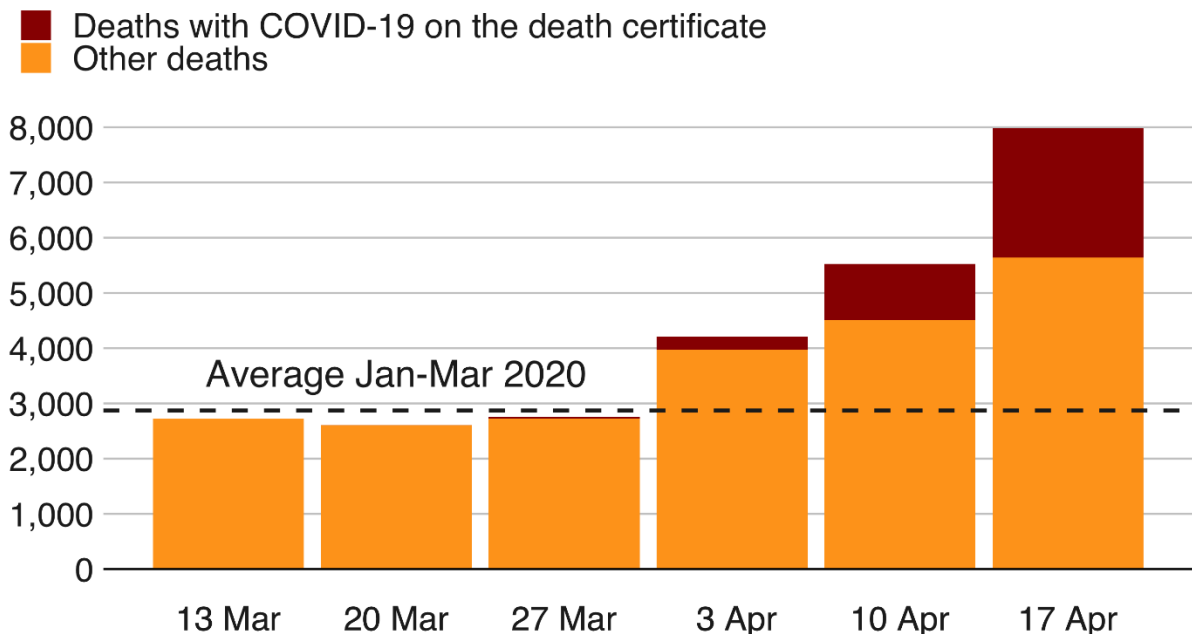
Residents and their loved ones are being distanced and prevented from normal close human contact by measures introduced to try to reduce infection rates.

Despite [Care Campaign for the Vulnerable](#) (CCFV), a national organisation that influences the care sector to operate more transparently, drawing much needed attention to [families' visiting rights](#), many elderly people are tragically dying in care homes without their loved ones at their beside.

The [death rate of care home residents due to Coronavirus](#) has increased alarmingly and is set to continue its seemingly relentless rise. Attributable causes include a [lack of adequate PPE](#) and hospitals discharging patients [untested for Covid-19](#) into care homes. It has been claimed that the [full Covid-19 care home death toll](#) may never be known.

Care home deaths are still rising

Weekly death registrations in care homes in Great Britain



Source: ONS, NRS

BBC

Whatever the underlying reasons for the dramatic increase, medically, it is recognised that once an elderly person becomes infected with the virus, death can occur rapidly.

A sudden, and often unexpected, death, greatly adds to the trauma experienced by not only absent family members, who may well have been deprived of a chance to say their goodbyes, but also for carers who have formed close bonds with their residents.

But there is an equally worrying issue that might be seen as contributing to the dreadful rise in the death toll in care homes.

Many residents have been unable to receive doctors' visits and therefore diagnosis and treatment as they did before Covid-19 struck.

What are the rights of care home patients to receive care, including medical attention?

Consumer Rights:

Residents have consumer rights, regardless of whether they pay all the costs of their care or whether some or all of their costs are paid for by their local authority, Health and Social Care Trust or NHS.- [Gov.uk](#).

Level of Care:

Care home staff must act with reasonable 'care and skill' and provide the service they said they would in the care home residence contract (see below). If they don't, residents may be able to claim compensation for breach of contract.

For example, care homes must ensure that their buildings and equipment are suitable and safe, and residents must be treated with 'dignity and respect'. If care homes claim to provide a particular type of care (such as palliative care), they should do so competently. [Gov.uk](#)

Care Home Contracts:

Care homes require a contract to be signed to agree terms of admission. It's essential to read these contracts very carefully and understand what is being agreed.

Which? provides useful [guidance](#) on what to be aware of.

However, the Which? guide on [questions to ask about care home contracts](#) does not include any about medical care provided by or obtained for residents.

[MHA's](#) (one of the largest care home providers) sample Residential Care Agreement does not specifically mention the right to medical care and treatment, although its definition of its "Services" does include "*personal care in accordance with the individual Care Plan*".

Other care homes admission contracts are similarly silent on the subject.

Right to Medical Care:

So, where are rights to receive medical care and treatment to be found and what do those rights look like?

The NHS Constitution (England):

“..establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.” [DHSS](#)

The Principles include:

1. The NHS provides a comprehensive service, available to all: i.e. ”irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status” (emphasis added)
2. Access to NHS services is based on clinical need, not an individual’s ability to pay.
5. The NHS works across organisational boundaries: “It works in partnership with other organisations in the interest of patients, local communities and the wider population.”

NHS Values as set out in the NHS Constitution include: “Everyone counts: We maximise our resources for the benefit of the whole community, and **make sure nobody is excluded, discriminated against or left behind.**” (emphasis added)

On Access to Health Services, the NHS Constitution says:

“You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.”

Human Rights:

In the UK, human rights are protected by the **Human Rights Act 1998**. Public authorities, like a local authority or the NHS, must follow the Act. [Which?](#)

[AgeUK](#) has analysed the application of human rights law as it applies to health care and treatment of the elderly as follows:

“Article 2: The Right to Life

I have the right to have my life protected and not to have it taken away by others.

What does this right mean?

Public authorities must:

take appropriate steps to protect a person’s life e.g. ensure adequate laws to protect you from others who might want to take away your life.

not take away a person’s life, except in a few very specific and limited circumstances.

It does not mean there is a right to medical treatment in all circumstances.

If someone dies as a result of the state’s use of force, or the state’s failure to protect life, there should be an effective official investigation into what happened.

How could this be relevant to me or other older people?

I should not be refused lifesaving medical treatment because of my age.

I need to be given enough to eat and drink whilst I am in the care of an institution.

I should not have a ‘do not resuscitate’ order placed on my file without my or, if I cannot express my own view, my family’s consent.

I should not be discharged from hospital if I am unable to look after myself, if there is no care in place to support me and if my life would be at risk as a result.

In the event that my death is suspicious or unexplained, an effective inquest must be carried out”

These are, on their face, a powerful set of rights that can help protect and safeguard the elderly. Enforcing those rights is another question and not strictly within the scope of this blog.

Public authorities include:

- social services
- private care homes funded by a local authority
- local authority and NHS funded care homes
- NHS health services like hospitals, GPs and dentists
- other NHS bodies like NHS trusts in England, Local Health Boards in Wales or NHS Health boards in Scotland
- private healthcare organisations providing NHS services
- the Care Quality Commission in England, the Care and Social Services Inspectorate in Wales and the Care Inspectorate in Scotland. (emphasis added)
Citizens Advice

There are therefore going to be some limitations on where human rights law impacts the elderly in care homes that are not funded by public authorities.

Regulation:

The Care Quality Commission publishes a Guidance for Providers on meeting the regulations. This contains several Regulations for care home providers to follow including:

Regulation: Person-centred care

“9.-(1) The care and treatment of service users must— (a) be appropriate, (b) meet their needs, and (c) reflect their preferences.”

*“(3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; (b) designing care or treatment with a view to achieving service users’ preferences and ensuring their needs are met; (c) enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment; (d) enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user’s care or treatment to the maximum extent possible; (e) **providing opportunities for relevant persons to manage the service user’s care or treatment**; (f) involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user’s care or treatment; (g) providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f); (h) **making reasonable adjustments to enable the service user to receive their care or treatment**; (i) where meeting a service user’s nutritional and hydration needs, having regard to the service user’s well-being” (emphasis added)*

The Summary of the Regulation states: *“The intention of this regulation is to make sure that people using a service have care or treatment that is personalised specifically for them. This regulation describes the action that providers must take to make sure that each person receives appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.”* [CQC Guidance](#)

NHS England Covid-19 Directives

On March 19 2020, NHS England sent a [letter to general practice](#) outlining measures being put in place for primary care preparedness.

This was succeeded by [regular updates from the NHS](#) to general practice regarding the emerging COVID-19 situation.

[The BMA](#) then issued its own [guidance to GPs](#) explaining how they can react to meet the new measures. This included *“Activities to Stop”*, which states:

“We advise that all non-urgent work be postponed until further notice. This might include:

- *travel advice and travel vaccinations*
- *new patient reviews*
- *over-75 health checks*
- *clinical reviews of frailty*
- *all routine CQC inspections (already enacted)..”*

On 27th March 2020, [NHS England wrote to all GPs and GPs and their Commissioners](#), with further guidance on how to respond to Covid-19 conditions:

This included extensive advice on GPS handling face-to-face patient consultations, which includes the following:

“It may be clinically necessary to come into direct contact with patients, for example, those identified most at risk, to provide them with the necessary treatment and care in a range of settings including the person’s own home, the GP practice, a local hub or an alternative care setting in the community.

To manage this effectively and avoid any risk of cross-infection, there will need to be separation in terms of how services are configured, staffing and patient flow management. This principle applies equally to providers of community services and social care.

In practice, the vast majority of patients with COVID-19 symptoms can be assessed and managed remotely. Routine care for these individuals can usually be postponed to a later date. However, there will be cases where face-to-

face assessment is required (eg COVID symptoms with an acute abdomen). These would need to be carefully managed either in a designated way on premises set up to deliver these services or by home visit, always with appropriate precautions and PPE.”

“In all variations, it will be vitally important to have strict infection control and decontamination proposals to minimise the risk of onward transmission from patients to healthcare workers and vice versa. That principle applies equally to home visits.” (emphasis added)

There is also a specific section on treating patients in care homes, which says:

“Care/nursing homes

*GPs should identify those on their most-at-risk list who live in a care or nursing home. **Regular care home rounds by GPs and/or their MDTs should be delivered virtually unless physical presence is required for clinical reasons.** GPs will need to work with community service providers (whose contracts will describe their responsibility in this respect) to co-ordinate their interventions. All health and care professionals who deliver care to these patients will need to follow strict infection control and decontamination protocols to keep themselves and others safe.”* (emphasis added)

Summary and Conclusions:

- It is clear that care home residents have the same rights to receive medical care and treatment from the NHS as everyone else.
- Those rights are enshrined in the NHS Constitution and reinforced by regulations.
- There are also human rights to be treated with care and respect that overlay these essential rights.
- Since the onset of Covid-19, a lot of regulations have been imposed to protect patients, medical providers from infection and spreading the virus.
- These include directions to GPs that impact upon their usual in-person and proximate service to the elderly within care home settings.
- The issue is whether the right to normal face-to-face examinations by GPs and care from NHS medical staff for the elderly is now overridden by directions in order to avoid cross-contamination.
- Guidance states that the vast majority of patients with COVID-19 symptoms can be assessed and managed remotely.
- It is apparent that there has been no clear ban on face-to-face GP consultations.
- GPs have some discretion within NHS England's Covid-19 GP guidance to decide if face-to-face consultation is appropriate and necessary.
- If they decide personal intervention is needed then extreme care has to be taken regarding infection control.
- This would seem to place GPs in an unenviable, unprecedented and highly conflicted position of having to make judgment calls about seeing patients they would normally visit and examine in person.
- Also, care home managers and staff and their elderly residents are especially challenged when GPs decide they cannot attend on patients in person.

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