17 March 2021

The Hon. Martin Foley MP
Minister for Health
Level 22
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MELBOURNE VIC 3000

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Dear Minister,

Recommendations to government for improved prevention and management of COVID-19 outbreaks in residential aged care facilities

In early October, AMA Victoria established an Aged Care Taskforce (Taskforce) because member groundswell warranted a Victoria-specific policy approach.

The objective of the Taskforce is to provide recommendations to government to ensure improved prevention and management of COVID-19 outbreaks in residential aged care facilities (RACFs). A copy has also been forwarded to the Victorian Aged Care Response Centre (VACRC).

The Taskforce has examined the *Victorian Residential and Aged Care Facility Plan*,[1] and the *CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia*[2] and used their lived-experience of the pandemic to identify gaps that require addressing and how communication and collaboration could be improved.

The COVID-19 pandemic has presented our aged care and health systems with challenges never experienced before in Australia, with that being even more pronounced in Victoria. AMA members have been closely monitoring the pandemic with many involved in aged care in a variety of settings and specialisations.

Early on in the pandemic it was noted from overseas reports that those in RACFs were the most vulnerable group to develop complications and die from the COVID-19 virus.[3] Given that these risks were known early, it is our view that there was a serious lack of preparedness for this risk, including planning for an aged care surge workforce.[4]

An examination of the pandemic response in the *Internal Medicine Journal* concludes that: *RACFs are required to provide skilled care for a unique, highly dependent population, making physical distancing impossibe. Facilities have not been designed with infection prevention strategies in mind and staffing ratios are highly variable. The catastrophic outcomes of this infection … around the world parralel the outcomes seen from cruise ships and urgent action is required to protect [RACF] residents, workers and the community at large.*[5]

Victorian AMA members note there was lack of alignment, coordination and collaboration in outbreak response between the Commonwealth and State Governments and other agencies, highlighting issues such as: confusion around who should be screened, contacted and quarantined in a RACF with a COVID-positive case; who had ultimate responsibility for the pandemic response; the role of GPs; differing guidance on cohorting positive residents; the development of 'health hubs' with little extra staffing or funding for acute services and GPs; new plans being continually changed and updated; and, a consultation and service structure that did not allow those who deliver the operational plan on the ground to have input into it.

[1] https://www.dhhs.vic.gov.au/aged-care-sector-coronavirus-disease-covid-19
[2] https://www.health.gov.au/sites/default/files/documents/2020/07/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia.pdf
[3] https://www.ilpnetwork.org/
[4] https://www.abc.net.au/news/2020-08-19/coronavirus-doctor-says-aged-care-surge-workforce-shortage/12569444
[5] Crotty, F, Watson, R. and Lim, Wen Kwang, Internal Medicine Journal, 50 (2020) 1033-1036, Royal Australasian College of Physicians, Received 23 April 2020; accepted 20 June 2020.

We must now proactively engage with all those involved in the care of older Australians, especially those involved in hands-on care, to prepare to respond to any further pandemics. We must also keep in mind that RACFs are homes where people live, not hospitals. Most of the care is provided by non-clinical/medical staff and the priorities for residents are care and kindness. Relationships that residents have with staff are pivotal to their wellbeing. We should also acknowledge the human rights of the residents in aged care and that their personal choices are important.

The recommendations from the AMA Victoria Taskforce focus on three areas: preparation and planning; the first 24-hours outbreak response; and, the ongoing response.

Much of the pandemic response was reactionary. We now have the chance to be proactive in our planning.

We would welcome discussing these recommendations with you.

Yours sincerely,

Associate Professor Julian Rait OAM

AMA VICTORIA PRESIDENT

GLOSSARY

ACD (Advance Care Directive)

ACFI (Aged Care Funding Instrument)

ACRC (Aged Care Royal Commission)

ACQSC (Aged Care Quality and Safety Commission)

ANZSPM (Australian & New Zealand Society of Palliative Medicine)

BC (British Columbia)

AHPPC (Australian Health Protection Principal Committee)

AHPRA (Australian Health Practitioner Regulation Agency)

CDC (Centre for Disease Control)

CDNA (Communicable Diseases Network Australia)

CHO (Chief Health Officer)

CPC (Community Palliative Care)

DHHS (Department of Health and Human Services)

DoH (Department of Health)EMMV (Emergency Management Manual Victoria)

GP (General Practice/Practitioner)

GPLO (General Practice Liaison Officer)

ICP (infection Control Practitioner)

IPC (Infection Prevention and Control)

LTC (Long-Term Care)

PCA (Personal Care Attendant)

PHN (Primary Health Network)

PPE (Personal Protective Equipment)

RACF (Residential Aged Care Facility)

RIR (Residential-in-Reach program)

RN (Registered Nurse)

VACRC (Victorian Aged Care Response Centre)

SUMMARY OF RECOMMENDATIONS

PREPARATION AND PLANNING

COVID-19 difficult to contain in RACFs

Recommendations:

- **Capital funding to support RACFs to prepare infrastructure in order to implement infection control measures and design, such as single rooms and ensuites, ventilation and air conditioning. Considering the vital role of telehealth in providing care, IT infrastructure, particularly adequate WIFI, must also be appropriately funded;**
- **Approval and funding for a RACF General Practice Liaison Officer (GPLO) and project management role and evaluate outcomes for improved coordination of care and medical services. The GPLO would, amongst other roles, instruct staff in how to conduct telehealth video consultations.**
- **Upskill the aged care workforce. Where appropriate (such as where staff are required to interpret guidelines and follow written protocols), require mandatory and minimum credentialing in English . Moreover, require training in infection control, medication dispensing; dementia and end-of-life care; and optimise the industrial environment to support increased skill levels required, permanent employment and one worker one site;**
- **Ensure access to an Australian Health Practitioner Regulation Agency (APHRA) Registered Nurse 24/7;**
- **Require that an AHPRA registered health professional is the RACF manager; and**
- **Ensure PPE supplies are available to RACFs as a matter of priority (and ensure that RACFs distribute the PPE to residents and staff appropriately).**

Conflicting advice and unclear authority

Recommendations:

- **Commonwealth and State governments must come together and define roles and responsibilities with a common set of principles to guide preparation and response to future outbreaks;**
- **It is essential that a national body exists to bring together clinical expertise about aged care sector infection control and emergency preparedness in the context of knowledge of the settings and the delivery of care. To this end, the newly established Aged Care Advisory Group within AHPPC should be made a permanent national body. This body should:**
    - **have members with expert hands-on aged care expertise, to advise on: how aged care works; dementia care; palliative care; and, infection control, among other matters;**
    - **develop clear and consistent guidelines and processes with respect to prevention of COVID-19 infection and transmission, screening, testing, use of PPE, isolation, lockdown and transfers to hospital – with input from clinicians on-the ground;**
    - **ensure uniformity and cooperation between State and Federal government bodies in response to health care issues, recognising the interplay between these systems with aged care;**
    - **ensure uniformity of guidelines between health services;**
    - **coordinate and disseminate a single source of timely, clear and consistent information to ensure consistency and reduce the risk of conflicting information;**
    - **streamline the collection of data which can then be shared by the various agencies requesting information;**
    - **manage risks in workforce, infection control, governance, and the capability of individual providers; and**
    - **focus on providing older Australians with better access to the wider health system, including primary care, palliative care, and other specialists, along with acute care, mental health, allied health and oral health services.**
- **Support a general practice patient-centred medical home care model for all residents in a RACF; and**
- **Retaining and increasing the number of GPs, geriatric medicine specialists and psychiatrists working in aged care to provide appropriate clinical care.**

Cohorting and security of tenure issues

Recommendation:

- **Advise RACFs of the 'emergency situations' provision in the *Aged Care Act 1997* and how this, in certain circumstances, supersedes the 'security of tenure' provision.**

FIRST 24-HOURS OUTBREAK RESPONSE

Conflicting advice over hospitalisation of COVID-19 positive aged care residents

Recommendations:

- **The development of clear guidelines on the care location for COVID-19 positive residents using the experience of those providing hands-on care and the latest research, whether it is for required acute care or for isolation to prevent cross-infection to other aged care residents. As a first principle, every infected RACF resident must have the right to acute care if required. Where acute care is not required, the appropriateness of quarantining/isolating a resident at the RACF will depend on the particular circumstances/capabilities of the RACF;**
- **The examination of the development of designated COVID-19 facilities where positive residents can be cared for by dedicated staff. These specialised facilities should be fit for purpose, expertly staffed, well resourced, supported by GPs, palliative care nurses, palliative care physicians and geriatricians to care for frail elderly residents;**
- **Formation of a panel of infection control experts and teams who could immediately deployed to residential aged care facilities to assist the facility with infection control procedures;**
- **An infection control trained staff member in every facility who could link directly to the aged care specific panel of infection control experts at the time of an outbreak;**
- **An audit of the impact of transfer and care of RACF patients not requiring acute hospital care in Victoria's RACF outbreaks should be established immediately and be implemented to enable real time monitoring in future outbreaks;**
- **The development, with relevant multi-agency clinicians (including disaster medicine experts and ambulance officers), of an emergency response and mass transfer plan for residents should an outbreak result in the need for RACF closure, or in the resetting of the existing plans for accommodation of RACF residents should their own RACF be overwhelmed (as occurred in the 2020 Victorian RACF outbreaks);**
- **Ensuring there are beds available elsewhere that better meet Infection Control and Prevention (IPC) standards if we are transferring residents from their RACF and**
- **'Stress/scenario testing' current models of outbreak response to ensure weaknesses identified and optimised.**

Workforce impacts

Recommendations:

- **Hiring and rapid training of a surge workforce for RACFs;**
- **Governments to consider creating and funding a reserve squad of staff that can be deployed to RACF during an outbreak to protect RACF residents;**
- **Being the chief funder and the regulator of the aged care sector, the Federal Government should take further action to ensure that the funds directed to the sector guarantee sufficient staff numbers and sufficiently trained staff availability;**
- **All staff caring for residents should have accredited and documented training and certification in infection prevention and control, PPE use, standard precautions, and transmission-based precautions;**
- **Ongoing training of staff should be conducted regularly by Infection Control Practitioners (ICP);**
- **Use of infection control expertise within local health districts to support RACFs;**
- **Examine the casualisation of the workforce and develop a plan to improve workforce conditions to discourage working across multiple sites;**
- **Funding for each facility to train a staff member to have up-to-date training in infection control and in education to enable training of other staff members;**
- **There should be a process established for the recruitment/training of younger doctors in rural and regional areas, who could visit RACFs and be supervised by the resident's usual GP via telehealth;**

- **Ensure the contribution of aged care managers by videoconference, where all staff have been furloughed, as they know the residents and facility; and**
- **Continuity of access to the electronic resident record system.**

Pre-emptive atypical screening of residents and surveillance screening/testing of staff

Recommendations:

- **Required atypical symptom screening for all residents of all RACFs in any community where there is an identified positive case;**
- **Required surveillance screening/testing for all RACF staff in any community where there is an identified positive case; and**
- **Appropriate resourcing to make both possible.**

COVID-19 testing

Recommendations:

- **Testing of all residents should start when the first resident has symptoms, as outbreaks in RACF have the potential to spread quickly with large mortality rates;**
- **Testing should be undertaken on asymptomatic residents and staff if there is a positive case in the RACF;**
- **Surveillance screening of residents, staff and visitors should be implemented according to emerging evidence best practice principles; and**
- **Consider advance contact tracing of staff.**

Support through the Residential-in-Reach Program (RiR)

Recommendations:

- **Further support for RiR is required to care for COVID-19 positive residents in RACFs;**
- **Further support for GPs and staff to care for COVID-19 positive residents;**
- **Ensure RiR flex capacity as when outbreaks occurred services were significantly under resourced;**
- **Ensure palliative care services are supported to work in collaboration with RiR team;**
- **Ensuring HUB response has a detailed operational, fit for purpose plan tailored to each individual HUB, and sufficient resourcing to implement in planning, prevention and response phases. Ensuring direct clinician involvement in development and refinement of HUB planning at VACRC level, beyond HUB leads; and**
- **Ensure RIR and HUB outbreak response plans "scenario/stress" tested to investigate and address weaknesses.**

Advance care planning

Recommendations:

- **Where appropriate, residents should be encouraged, in a sensitive manner, to review and update their ACDs in light of the current COVID-19 crisis;**
- **Advance care planning should form an integral part of person-centred care in aged care and that implementing and respecting ACDs should form an integral part of any clinical governance in aged care;**
- **Educational support for GPs to undertake ACD discussions and preparation;**
- **RACFs need to be adequately resourced in order to meet the needs of residents who would prefer to avoid hospital transfer. Even outside of COVID-19, RACF are not setup, particularly after-hours, to assess or manage residents that have acutely deteriorated; and**
- **Decisions to transfer residents who have lost decision-making capacity to hospital should be undertaken in consultation with: the resident's substitute decision-maker and usual GP; taking into**

account the resident's ACD; the resident's known values and goals of care; and, the wider public health strategy.

ONGOING RESPONSE

The important role of general practitioners in aged care

Recommendations:

- **Facilitate GPs becoming members of RACF clinical governance teams; and**
- **More specific medical access standards should be developed for RACFs as part of the Aged Care Quality Standards to help improve access to medical services and clinical care.**

Issues with coordination of primary, specialist and acute care

Recommendations:

- **Recognise the importance of, and support a system of care, where each resident is provided with comprehensive GP care (e.g. by supporting the RACF GPLO position, incorporating GP expertise in clinical management groups, DoH leadership groups, and having Primary Health Networks (PHNs) support GPs with secondary referral and support.**

Centre for Disease Control (CDC)

Recommendations:

- **The establishment of a CDC which would:**
  - **enable Australia to have a national focus on current and emerging communicable disease threats, and to engage in global health surveillance, health security, epidemiology, research and evidence-based policy making;**
  - **manage pandemic threats in a more co-ordinated manner, and be better prepared for future outbreaks;**
  - **direct the policy and provide general guidance and direction in any future potential outbreaks in RACFs; and**
  - **eliminate some of the overlaps and inefficiencies from the lack of coordination between the Federal and State/Territory administrations.**

Learnings from the overseas experience

Recommendation:

- **Examination of the overseas experience in dealing with the COVID-19 Pandemic in RACFs to inform current and future planning.**

Risk rating

Recommendations:

- **An urgent national audit of RACFs to identify and prioritise risks and, the organisation's capability to respond using existing information. This would identify those most vulnerable and least equipped to manage should an outbreak occur; and**
- **Assess the ability of all RACFs to safely cohort residents and the capacity to provide a safe environment.**

Telehealth for RACF residents

Recommendation:

- **Introduce an MBS telehealth item for telehealth between the GP, RACF staff and relatives; and**
- **The Government to consider undertaking a pilot of telehealth for RACF for after-hours consultations. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision-making.**

Training of aged care staff

Recommendation:

- **Infection prevention and control training should be a core component of induction of anyone starting work in RACF. Continuous training refreshers and competency audits for RACF staff should also be required and facilitated.**

Improved palliative care guidelines for RACFs

Recommendations:

- **Improve the palliative care guidelines for COVID-19 positive residents, recognising the work that the Australian & New Zealand Society of Palliative Medicine (ANZSPM) has already undertaken in this area;**
- **Ensure that RACFs have adequate staffing and supplies of palliative medicine available including provision of adequate subcutaneous medications to RACF residents by nurses who are trained to administer it;**
- **Increase the number of RNs with palliative care skills in RACFs; and**
- **Reinforce the linkage and provision of care by community palliative care services.**

Support and follow-up for staff, residents and families involved in outbreaks

Recommendation:

- **Monitoring for adverse impact on RACF staff and provision of appropriate support where required should be immediately implemented.**

PREPARATION AND PLANNING

COVID-19 difficult to contain in RACFs

The environment of RACFs contributes to the high risk of a COVID-19 outbreak, such as:

- shared accommodation and communal spaces;
- the large number of people in a relatively small space;
- the physical environment being home-like and not clinical or designed for infection control;
- a workforce trained to deliver personal care needs and not the clinical care required for a pandemic;
- a workforce that works across a number of locations thought to be responsible for 20% of the outbreaks in RACFs; and,
- staffing and skill levels that are very different compared to acute and sub-acute areas. While Victorian public sector aged care facilities have legislated staffing levels under the *Safe Patient Care Act*,[6] these do not apply to non-government RACFs.

In addition, with 70% of RACFs residents having some cognitive impairment and others with physical disability, it makes it difficult for them to adhere to social distancing and handwashing which increases spreading risk. As of 30 June 2019, 64% of people in permanent residential aged care were rated with a high care need for cognition and behaviour.[7]

Best-practice approaches to reducing the spread of infections in RACFs can also relate to capital infrastructure such as facility design, specialised ventilation and air conditioning, at a time where there is limited funding available for capital works.

Considering the vital role of telehealth in the treatment of many RACF residents and the overall management of the pandemic, IT infrastructure, particularly high-speed internet, must also be appropriately funded.

Some AMA Victoria members have raised fundamental problems with personal care workers (PCW) with limited English and communication skills; limited infection control knowledge; and, limited knowledge of medication management. Proficiency in English needs to be appropriate to the circumstances. Where staff are required to read and apply complex guidelines and protocols, a higher level of proficiency will be required.

It should be noted that many RACFs were unable to obtain sufficient personal protective equipment (PPE) from the National Medical Stockpile (NMS).[8] Data provided to a recent Senate Inquiry shows that 2,865 aged care providers requested PPE, but only 1,324 of those requests were approved. In Victoria in July and August – the peak of the pandemic – 1,180 homes made requests for PPE with 364 declined. Earlier, in March as cases were beginning to escalate, 696 of the 910 requests made for PPE were rejected . It is equally important that RACFs distribute PPE to staff and residents appropriately. Owing to concerns about future supply, AMA Victoria is aware of RACFs hording PPE and being parsimonious in its distribution.

Recommendations:

- **Capital funding to support RACFs to prepare infrastructure in order to implement infection control measures and design, such as single rooms and ensuites, ventilation and air conditioning. Considering the vital role of telehealth in providing care, IT infrastructure, particularly adequate WIFI, must also be appropriately funded;**
- **Approval and funding for a RACF General Practice Liaison Officer (GPLO) and project management role and evaluate outcomes for improved coordination of care and medical services. The GPLO would, amongst other roles, instruct staff in how to conduct telehealth video consultations.**
- **Upskill the aged care workforce. Where appropriate (such as where staff are required to interpret guidelines and follow written protocols), require mandatory and minimum credentialing in English . Moreover, require training in infection control, medication dispensing; dementia and end-of-life care; and optimise the industrial environment to support increased skill levels required, permanent employment and one worker one site;**

[6] https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act

[7]

[8] https://www.theweeklysource.com.au/federal-government-turned-down-ppe-requests-from-over-1500-aged-care-homes/?utm_medium=email&utm_campaign=The%20Daily%20RESOURCE%2030%20October%202020&utm_content=The%20Daily%20RESOURCE%2030%20October%202020+CID_16515c8f503b9146206e18032b219abc&utm_source=Campaign%20Monitor%20EDM&utm_term=Continue%20Reading

- **Ensure access to an Australian Health Practitioner Regulation Agency (APHRA) Registered Nurse 24/7;**
- **Require that an AHPRA registered health professional is the RACF manager; and**
- **Ensure PPE supplies are available to RACFs as a matter of priority (and ensure that RACFs distribute the PPE to residents and staff appropriately).**

Preparation and planning guidelines

The first document the Commonwealth Government released to assist aged care providers with the COVID-19 pandemic was the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* on 7 February 2020.[9] Prepared by the Department of Health (DoH), the document was directed at the whole health care system, not aged care specifically.

The *Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities*,[10] prepared by the Communicable Diseases Network Australia (CDNA), was released on 13 March - an adaptation of the CDNA's *National Influenza Outbreaks in Residential Care Facilities in Australia*.[11] On 17 March the Aged Care Quality and Safety Commission, required RACFs to perform a self-assessment survey with questions based largely on the CDNA guidelines.[12]

There appears to have been little or no follow-up by authorities on preparation for a pandemic. On 12 August, the Royal Commission into Aged Care Quality and Safety (ACRC) hearings on COVID-19 noted that: '*the ACRC will be submitting that the sector was not well prepared*'. The Senior Counsel added that the high level of risk demanded a level of preparedness that was also very high: *'The Federal Government which has sole responsibility for aged care was firmly on notice early in 2020 of the many challenges that the sector would face to the outbreaks to COVID-19.'*[13]

Counsel also noted that, while the CDNA has 24 members, none are general practitioners or aged care specialists and that their Guidelines were based on previous work on influenza outbreaks in RACFs which: *'may partly explain why some providers may have thought their existing influenza plan would hold them in good stead for COVID-19, only to find that they were left unprepared.'*[14]

The Victorian State Government response to COVID-19 has been predominantly managed under the *Public Health and Wellbeing Act 2008* (PHWA).[15] The PHWA places significant powers in Victoria's Department of Health and Human Services (DHHS) and its Chief Health Officer (CHO) to investigate, eliminate or reduce a risk to public health under the Emergency Management Manual Victoria (EMMV).[16]

The Commonwealth-led Victorian Aged Care Response Centre[17] was established in August 2020 to oversee the operational response for aged care homes impacted by COVID-19.

In response to increasing numbers of COVID-19 infections in Victorian RACFs, on 19 July the Commonwealth and Victorian governments jointly announced they would introduce measures to reduce transmission including funding to:

- enable employees to work at a single site;
- engage and train new staff;
- support for staff unable to work;
- alternative accommodation so workers in hotspots could continue to work;
- more infection control training;
- the prioritisation of contact tracing in aged care;
- the deployment of five new COVID-19 testing teams to test staff and residents in RACFs located across metropolitan Melbourne and the Mitchell Shire; and,
- work with private hospitals so they can support the response to outbreaks in aged care facilities.[18]

While the plans provided a good framework, many Victorian AMA members are concerned that they don't get to the real lived-experience of clinicians – the 'coalface truth'.

[9] www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19
[10] www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-guidelines-for-outbreaks-in-residential-care-facilities.pdf
[11] www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-flu-guidelines.htm
[12] https://www.agedcarequality.gov.au/covid-19-coronavirus-information
[13] agedcare.royalcommission.gov.au/media/28056
[14] agedcare.royalcommission.gov.au/sites/default/files/2020-08/13%20August%202020%20-%20Transcript.pdf
[15] www.legislation.vic.gov.au/in-force/acts/public-health-and-wellbeing-act-2008/043
[16] www.emv.vic.gov.au/policies/emmv
[17] www.health.gov.au/initiatives-and-programs/victorian-aged-care-response-centre
[18] www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/support-for-aged-care-residents-and-aged-care-workers-across-victoria

Conflicting advice and unclear authority

Because of the large number of agencies involved in providing advice to RACFs in dealing with an outbreak, some issues arose due to inconsistent and conflicting information from agencies including DoH, the Aged Care Quality and Safety Commission (ACQSC), the Victorian DHHS, Safer Care Victoria, Work Safe Victoria and the Commonwealth Chief Medical Officer.

In a pandemic scenario, uniform direction and clear and consistent lines of information that are easily identified and accessible are critical, and existing convoluted hierarchies and multiple responsible bodies with roles in the aged care sector do not allow this to occur.[19] As was found in the Newmarch Review in the context of an outbreak in a NSW RACF: '*interagency operations were characterised by a lack of clarity in the relationships and hierarchy among government health agencies.*'[20] The same can be said of the broader Victorian experience. When clusters emerged in non-government facilities, there were frequent instances where State and Federal bodies did not have plans in place to address this. In these circumstances, it was not clear which government body had responsibility for coordination or management of these processes.

Victorian AMA members also note that many aged care providers raised concerns about the number of data requests from various agencies, which were often duplicative in nature, resulting in a significant confusion and administrative burden taking time away from clinical care.

Recommendations:

- **Commonwealth and State governments must come together and define roles and responsibilities with a common set of principles to guide preparation and response to future outbreaks;**
- **It is essential that a national body exists to bring together clinical expertise about aged care sector infection control and emergency preparedness in the context of knowledge of the settings and the delivery of care. To this end, the newly established Aged Care Advisory Group within AHPPC should be made a permanent national body. This body should:**
    - **have members with expert hands-on aged care expertise, to advise on: how aged care works; dementia care; palliative care; and, infection control, among other matters;**
    - **develop clear and consistent guidelines and processes with respect to prevention of COVID-19 infection and transmission, screening, testing, use of PPE, isolation, lockdown and transfers to hospital – with input from clinicians on-the ground;**
    - **ensure uniformity and cooperation between State and Federal government bodies in response to health care issues, recognising the interplay between these systems with aged care;**
    - **ensure uniformity of guidelines between health services;**
    - **coordinate and disseminate a single source of timely, clear and consistent information to ensure consistency and reduce the risk of conflicting information;**
    - **streamline the collection of data which can then be shared by the various agencies requesting information;**
    - **manage risks in workforce, infection control, governance, and the capability of individual providers; and**
    - **focus on providing older Australians with better access to the wider health system, including primary care, palliative care, and other specialists, along with acute care, mental health, allied health and oral health services.**
- **Support a general practice patient-centred medical home care model for all residents in a RACF; and**
- **Retaining and increasing the number of GPs, geriatric medicine specialists and psychiatrists working in aged care to provide appropriate clinical care.**

Cohorting and security of tenure issues

Many AMA Victoria members raised concerns about some RACFs refusing to implement cohorting rules, claiming that residents cannot be isolated/moved due to 'security of tenure' arrangements. Guidance from DoH states that:

[19] https://www.theweeklysource.com.au/air-of-bullying-ciaran-foley-slams-government-and-health-authorities-over-covid-aged-care-advice/?utm_medium=email&utm_campaign=The%20Daily%20Resource%2018%20August%202020&utm_content=The%20Daily%20Resource%2018%20August%202020+CID_94c4f5e463e35a16f3a9e129f8831ab6&utm_source=Campaign%20Monitor%20EDM&utm_term=Continue%20Reading

[20] https://www.health.gov.au/sites/default/files/documents/2020/08/newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf

If there is an instance of confirmed or [suspected] cases of COVID-19 in an aged care home … there may be a need to temporarily move a resident to another room within a facility, or in some circumstances to a different care location. These circumstances differ from the usual principles described in the User Rights Principles, as it would likely be considered an emergency situation in accordance with the principles.

If an aged care facility is not suitable for the isolation of a resident with COVID-19, the Public Health Orders require that person to travel directly to a suitable place to reside in until they are medically cleared. Compliance with the Public Health Orders would therefore permit residents to be moved to other appropriate care locations temporarily. The decision whether an aged care facility is suitable is made by the State or Territory Public Health Unit in consultation with the aged care provider, resident and their family.

In situations, however, where an aged care facility wanted to permanently move a resident to a new room or out of the facility, then normal security of tenure arrangements apply during the COVID-19 pandemic.[21]

Recommendation:

- **Advise RACFs of the 'emergency situations' provision in the *Aged Care Act 1997* and how this, in certain circumstances, supersedes the 'security of tenure' provision.**

[21] https://www.health.gov.au/news/newsletters/protecting-older-australians-covid-19-update-14-may-2020#security-of-tenure-during-covid19

Issues with undertaking isolation within a RACF

On 25 June, the Commonwealth Government published a guideline entitled *First 24 hours: Managing COVID-19 in a residential aged care facility*.[22] This states that if a COVID-19 positive case is a resident they:

- Should be immediately isolated in a single room with an *ensuite*, if possible.
- May be transferred to hospital or other accommodation if clinically required.
- Older facilities where residents share rooms or bathrooms may require off-site cohorting.

There are many older-style RACFs with shared rooms remaining in operation. There is little guidance on where off-site cohorting could occur if a COVID-19 positive resident is unable to transfer to a single room and does not require transfer to hospital or other accommodation for clinical care.

Conflicting advice over hospitalisation of COVID-19 positive aged care residents

There are conflicting perspectives on whether COVID-19 positive residents should be transferred to hospital either for clinical need, or to isolate and prevent cross infection.[23] This also needs to take into consideration the needs of COVID-negative residents.

The position taken in Victoria is that hospital transfer decisions are made on a case by case basis by an appropriate healthcare professional. The VACRC is responsible for overseeing the operational response for COVID-19 impacted RACFs - including decisions on whether to transfer residents who are not clinically assessed as needing acute care in hospital.

The SA Government made the decision that all residents testing positive to COVID-19 in South Australian aged care homes would be transferred to a public hospital by ambulance to reduce the risk of transmission to other residents: '*as a public health response to ensure the resident has access to appropriate medical care if needed and to protect other residents and staff from exposure.*'[24]

Epidemiologist, Professor Mary-Louise McLaws stated at the ACRC that COVID-19 positive residents need to be cared for away from the main building, either in hospitals, or in a purpose-built facility: '*Regardless of each state's ability to take residents into hospitals…they need to be removed and put somewhere else that's safe and looked after by highly trained staff. Given that, both negative and positive residents have equity.*'[25]

Infectious disease specialist, Professor Lyn Gilbert, was commissioned to write a report about the Dorothy Henderson Lodge (DH Lodge) COVID-19 outbreak. [26] She credited the success of DH Lodge in containing the COVID-19 outbreak to the prompt and thorough response of management and staff and the policy of initially hospitalising all COVID-positive residents. The report states: The NSW Health policy of hospitalising all positive residents in the first week of an outbreak has allowed residents to receive the care they needed and allowed the RACFs to stabilise its workforce and establish its response.[27]

A paper in the *Internal Medicine Journal* notes that current guidelines recommending transfer of a RACF resident to hospital 'only if a resident's condition requires it' is worth reconsidering. They state that it is clear from experience that inadequate outbreak management in a RACF is likely to lead to high mortality and broader community transmission leading to higher burdens on hospitals.[28]

The authors outline three options for management of COVID-19 infections in RACFs. The first is to transfer all suspected or confirmed COVID-19 cases to an acute hospital setting; the second is cohorting to specific COVID-19 facilities; and, the third to cohort within a resident's own RACF. These last two options would require a highly trained, mobile workforce available to be deployed at the beginning of an outbreak; and, would require exposing residents to new unfamiliar environments, as they would be if transferred to hospital.

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[22] https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility

[23] www.theweeklysource.com.au/greg-hunt-says-covid-positive-aged-care-residents-must-be-admitted-to-hospital-as-doctors-warn-of-bed-blockers-filling-wards-to-capacity/

[24] www.sahealth.sa.gov.au/wps/wcm/connect/1a6171b8-49da-4e1b-a17c-03df3ac7873f/20200602+-+Management+of+COVID-19+in+RACF+-+Information+for+residents+and+families+%282%29.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-1a6171b8-49da-4e1b-a17c-03df3ac7873f-na1BAB4

[25] https://agedcare.royalcommission.gov.au/system/files/2020-08/RCD.9999.0384.0001.pdf

[26] https://agedcare.royalcommission.gov.au/media/28013

[27] https://agedcare.royalcommission.gov.au/media/28013

[28] Crotty, F, Watson, R. and Lim, Wen Kwang, Internal Medicine Journal, 50 (2020) 1033-1036, Royal Australasian College of Physicians, Received 23 April 2020; accepted 20 June 2020.

The authors state that cohorting residents within their own facility would not completely remove the risk they pose to other residents and that, should our health services be overwhelmed by the pandemic, specialist facilities established in collaboration with hospital services could care for COVID-19 positive residents.[29]

In a submission to the ACRC, the Federal AMA states that government should consider amending cohorting guidance to allow for entirely separate facilities where COVID-19 patients would be isolated and treated, preventing transmission inside a RACF: '*trying to isolate a positive case in situ is not feasible and the best way to contain the transmission is to isolate all infected residents in a separate area with separate staff, separate meals, and equipment.*'[30]

This approach would require further consideration by health experts and epidemiologists, as there are other factors to be taken into consideration, including the need to minimise distress and dementia-friendly environments. Many members have raised concerns that private hospitals are not fit for this purpose, and lacked infrastructure, protocols and appropriately credentialed and trained staff to care for large numbers of aged care residents who did not require acute hospital care.

One AMA member noted that: *'the strategy of keeping positive patients [in their RACF] for most places I would think is not viable, it is impossible to contain with current RACF environmental setup. An emphasis on transferring COVID patients out with their consent would not only protect the other residents but also likely to reduce staff furloughing and avoidance of an unstable workforce which then carries its own risks in terms of transmission of virus for those working in an unfamiliar facility with no institutional knowledge of the residents.*'

Recommendations:

- **The development of clear guidelines on the care location for COVID-19 positive residents using the experience of those providing hands-on care and the latest research, whether it is for required acute care or for isolation to prevent cross-infection to other aged care residents. As a first principle, every infected RACF resident must have the right to acute care if required. Where acute care is not required, the appropriateness of quarantining/isolating a resident at the RACF will depend on the particular circumstances/capabilities of the RACF;**
- **The examination of the development of designated COVID-19 facilities where positive residents can be cared for by dedicated staff. These specialised facilities should be fit for purpose, expertly staffed, well resourced, supported by GPs, palliative care nurses, palliative care physicians and geriatricians to care for frail elderly residents;**
- **Formation of a panel of infection control experts and teams who could immediately deployed to residential aged care facilities to assist the facility with infection control procedures;**
- **An infection control trained staff member in every facility who could link directly to the aged care specific panel of infection control experts at the time of an outbreak;**
- **An audit of the impact of transfer and care of RACF patients not requiring acute hospital care in Victoria's RACF outbreaks should be established immediately and be implemented to enable real time monitoring in future outbreaks;**
- **The development, with relevant multi-agency clinicians (including disaster medicine experts and ambulance officers), of an emergency response and mass transfer plan for residents should an outbreak result in the need for RACF closure, or in the resetting of the existing plans for accommodation of RACF residents should their own RACF be overwhelmed (as occurred in the 2020 Victorian RACF outbreaks);**
- **Ensuring there are beds available elsewhere that better meet Infection Control and Prevention (IPC) standards if we are transferring residents from their RACF and**
- **'Stress/scenario testing' current models of outbreak response to ensure weaknesses identified and optimised.**

Workforce impacts

There are a number of significant issues impacting on the workforce at this challenging time. It was noted at the ACRC COVID-19 hearing that the Federal government did not expect RACF staff absentee rate to be over 20-30%. In his remarks at the ACRC COVID-19 hearings, Counsel Assisting, Peter Rozen QC, said providers at the centre of an outbreak should 'plan to lose close to their entire workforce in the first few days of an outbreak'.[31] In the Newmarch

[29] Crotty, F, Watson, R. and Lim, Wen Kwang, Internal Medicine Journal, 50 (2020) 1033-1036, Royal Australasian College of Physicians, Received 23 April 2020; accepted 20 June 2020.
[30] https://agedcare.royalcommission.gov.au/media/28414
[31] https://insideageing.com.au/aged-care-homes-should-prepare-to-lose-all-their-staff-if-they-have-covid-19-royal-commission/

Review, it was found that 87% of the Anglicare frontline personal carers and nursing staff had to furloughed to isolation or quarantine.[32]

In addition, the skill level required to practice a high level of infection control measures would be beyond many of the staff working in RACF, particularly Personal Care Attendants (PCA's) and domestic staff. Also, the casualisation of the workforce leading to PCA's working across several facilities has been found to be a risk of spread of the virus.

Other AMA members found that where aged care staff were stood down or furloughed, they were sidelined by the incoming surge workforce leading to chaotic scenes. There should have been the ability for the managers to contribute via video-conferencing as they know the residents and the facility. Doctors were also often unable to identify residents – particularly those with dementia.

In this context, it is also important to note continuity of access to the electronic resident record system. The loss of staff and management during the outbreak in Newmarch House led to temporary loss of access to electronic records, and the surge staff had to revert to paper-based records. This move also impacted the GPs who were unable to access the iCare system remotely and prescribe properly for their patients. The Newmarch Review recommended that *'Approved Providers should consider the implications of a loss of Electronic Records as part of its Business Continuity Plan. Access and implications for all parties using the electronic records should be considered'*. A similar situation occurred at the St Basil's RACF where the surge staff didn't even know the residents' names or whether they were at the facility.

Recommendations:

- **Hiring and rapid training of a surge workforce for RACFs;**
- **Governments to consider creating and funding a reserve squad of staff that can be deployed to RACFs during an outbreak to protect RACF residents;**
- **Being the chief funder and the regulator of the aged care sector, the Federal Government should take further action to ensure that the funds directed to the sector guarantee sufficient staff numbers and sufficiently trained staff availability;**
- **All staff caring for residents should have accredited and documented training and certification in infection prevention and control, PPE use, standard precautions, and transmission-based precautions;**
- **Ongoing training of staff should be conducted regularly by Infection Control Practitioners (ICP);**
- **Use of infection control expertise within local health districts to support RACFs;**
- **Examine the casualisation of the workforce and develop a plan to improve workforce conditions to discourage working across multiple sites;**
- **Funding for each facility to train a staff member to have up-to-date training in infection control and in education to enable training of other staff members;**
- **There should be a process established for the recruitment/training of younger doctors in rural and regional areas, who could visit RACFs and be supervised by the resident's usual GP via telehealth;**
- **Ensure the contribution of aged care managers by videoconference, where all staff have been furloughed, as they know the residents and facility; and**
- **Continuity of access to the electronic resident record system.**

<u>Pre-emptive atypical screening of residents and surveillance screening/testing of staff</u>

AMA Victoria members believed that screening of residents and surveillance screening and testing of staff were essential measures to take as part of a policy of pre-emption, where there are cases in the community but not yet in the RACF.

Both also need to be appropriately resourced, as RACFs are presently under-equipped to screen and test consistently and effectively.

Recommendations:

- **Required atypical symptom screening for all residents of all RACFs in any community where there is an identified positive case;**
- **Required surveillance screening/testing for all RACF staff in any community where there is an identified positive case; and**
- **Appropriate resourcing to make both possible.**

[32] https://www.health.gov.au/sites/default/files/documents/2020/08/newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf

COVID-19 testing

AMA Victoria members were concerned that different jurisdictions were applying different rules around testing for COVID-19 and queried the guidance from health departments that RACF residents should be tested only if two or more residents show symptoms. AMA members welcomed the guidance around the management of COVID-19 outbreaks in RACF, but believes the guidelines could be improved by consistent national rules for testing of RACF residents.

Recommendations:

- **Testing of residents should start when the first resident has symptoms, as outbreaks in RACFs have the potential to spread quickly with large mortality rates;**
- **Testing should be undertaken on asymptomatic residents and staff if there is a positive case in the RACF;**
- **Surveillance screening of residents, staff and visitors should be implemented according to emerging evidence best practice principles; and**
- **Consider advance contact tracing of staff.**

Support through the Residential-in-Reach Program

To ensure aged care residents receive care in the most appropriate setting, the Victorian Government funds the Residential-in-Reach (RiR) program which provides hospital type care, where appropriate and safe, to people in residential aged care.[1] RiR comprises a specialised team of highly skilled nurses who help facilitate the best health outcomes for residents living in aged care facilities.

These specialist teams could be further utilised to provide acute care to COVID-19 positive residents in RACFs, in the absence of alternative appropriate facilities for those residents.

Recommendations:

- **Further support for RiR is required to care for COVID-19 positive residents in RACFs;**
- **Further support for and GPs and staff to care for COVID-19 positive residents;**
- **Ensure RiR flex capacity as when outbreaks occurred services were significantly under resourced;**
- **Ensure palliative care services are supported to work in collaboration with RiR team;**
- **Ensuring HUB response has a detailed operational, fit for purpose plan tailored to each individual HUB, and sufficient resourcing to implement in planning, prevention and response phases. Ensuring direct clinician involvement in development and refinement of HUB planning at VACRC level, beyond HUB leads; and**
- **Ensure RIR and HUB outbreak response plans "scenario/stress" tested to investigate and address weaknesses.**

Advance care planning

The COVID-19 pandemic has brought to the forefront the importance of having Advance Care Directives (ACDs), especially for residents of RACF. Having an ACD can have multiple benefits for residents, from preventing unnecessary hospital transfers to reducing anxiety for residents and their families.

While the *First 24 Hours Guidelines*[33] state that ACDs should be reviewed, and while this is important, it is difficult when dealing with a RACF COVID-19 outbreak.

An ACD specifying a person's preference not to be transferred to hospital in the event of illness should not prevent the resident being transferred to a separate area of the RACF or a separate COVID-19 designated facility to optimise their care.

Recommendations:

- **Where appropriate, residents should be encouraged, in a sensitive manner, to review and update their ACDs in light of the current COVID-19 crisis;**
- **Advance care planning should form an integral part of person-centred care in aged care and that implementing and respecting ACDs should form an integral part of any clinical governance in aged care;**

[33] Australian Government, Department of Health, First 24 Hours – Managing COVID-19 in a residential aged care facility, 29 June 2020.

- **Educational support for GPs to undertake ACD discussions and preparation;**
- **RACFs need to be adequately resourced in order to meet the needs of residents who would prefer to avoid hospital transfer. Even outside of COVID-19, RACFs are not setup, particularly after-hours, to assess or manage residents that have acutely deteriorated; and**
- **Decisions to transfer residents who have lost decision-making capacity to hospital should be undertaken in consultation with: the resident's substitute decision-maker and usual GP; taking into account the resident's ACD; the resident's known values and goals of care; and, the wider public health strategy.**

ONGOING RESPONSE

In preparing for current and future outbreaks or pandemics there is an urgent need to examine:

- the role of GPs in RACFs;
- the coordination of primary, specialist and acute care
- the experience and outcomes in Australia and overseas to identify what worked and what didn't.

There is also the urgent need to:

- Undertake risk rating of all RACFs to ensure readiness of all stakeholders;
- Establish an independent centre for disease control;
- Provide ongoing access to telehealth;
- Improve training for aged care staff;
- Improve palliative care guidelines; and
- Provide support and follow-up for staff, residents and families who have experienced the pandemic in their RACF.

The important role of general practitioners in aged care

In a submission to the ACRC, the Federal AMA maintains that future funding models for the health and aged care of older people need to recognise the important leadership role that GPs can play in providing advice on how to improve overall health outcomes beyond direct clinical needs.[34]

The Federal AMA contends that GP-led teams can advise on policy procedures, clinical governance, and an appropriately resourced care environment. The AMA has also previously noted that GPs can and should be members of clinical governance teams in RACFs, ensuring that appropriate clinical care procedures are established and followed and that governing bodies maintain a clinical focus.

AMA members also raised that the GP role was not recognised during the pandemic: they were not communicated with about their patients if they were COVID-19 positive; there were unclear, or lack of, agreed escalation pathways and transfer protocols and procedures; a lack of coordination and confusion over who would do what and when due to lack of preparedness or reduced staff capacity/furloughing; an undermining of the ability of a GP to manage care or influence outcomes of their patients due to not being involved in their management; the appointment of case coordinators and non-local GPs not being familiar with residents and local needs; and, a lack of clarity in some cases of who to contact, especially within the first 24-48 hours.[35]

This resulted in sub-optimal outcomes that were unacceptable for residents, families, treating clinicians, and the health care system, which require systems focussed solutions.[36]

Recommendation:

- **Facilitate GPs becoming members of RACF clinical governance teams; and**
- **More specific medical access standards should be developed for RACF as part of the Aged Care Quality Standards to help improve access to medical services and clinical care.**

[34] https://ama.com.au/sites/default/files/documents/AMA_submission_to_the_Royal_Commission_into_Aged_Care_Quality_and_Safety_FINAL.pdf
[35] PHN North Western Melbourne, Improving the Primary Care-led Health System Response to COVID-19 in Residential Aged Care Facilities, Sept 2020.
[36] PHN North Western Melbourne, Funding Proposal – Proof of Concept Plan for a General Practice Liaison Officer in Residential Aged Care, Draft 17 Sept 2020.

Issues with coordination of primary, specialist and acute care

AMA Victoria members have raised that there were significant issues in coordinating primary and acute health and specialist medical services during the pandemic which resulted in sub-optimal outcomes for residents, families, treating clinicians and the health care system, requiring systems-focused solutions.

AMA members also raised that the GP role was not recognised during the pandemic: they were not communicated with about their patients if they were COVID-19 positive; there were unclear, or lack of, agreed escalation pathways and transfer protocols and procedures; a lack of coordination and confusion over who would do what and when due to lack of preparedness or reduced staff capacity/furloughing; an undermining of the ability of a GP to manage care or influence outcomes of their patients due to not being involved in their management; the appointment of case coordinators and non-local GPs not being familiar with residents and local needs; and, a lack of clarity in some cases of who to contact, especially within the first 24-48 hours.[37] In sum, GPs felt ignored at best and actively undermined at worst.

This resulted in outcomes that were unacceptable for residents, families, treating clinicians, and the health care system, which require systems focussed solutions.[38]

Coordination of care and increased primary care capacity with clinical leadership in facilities have been identified as the highest priorities to address current needs. This recommendation has been informed by recent experience of more than 100 key stakeholders working in RACFs, including general practitioners, hospital residential-in-reach (RIR) services, emergency departments, pharmacists, facility staff and State and Commonwealth Governments.[39]

The North Western PHN has proposed a General Practice Liaison Officer (GPLO) role for RACFs in response to ongoing communication, coordination and process issues within aged care during the pandemic. This coordination function would:

- **Ensure a primary point of contact for all health care providers as needed:** For RACF nursing staff, General Practitioners (GPs), pharmacists, Health service visiting support teams (InReach, Hospital in the Home and similar), PHNs and DHHS. The contact point would be for communication, care and system coordination and development.
- **Ensure facility level clinical governance:** Develop, coordinate and oversight pathways and systems for clinical handover and care accountability between all stakeholders.
- **Coordinate timely COVID-19 testing, review, and contact tracing**
- **Deliver infection prevention and control support** for the facility, GPs, onsite personnel. Develop infection control and prevention models.
- **Assist the facility with proactive and timely communications** to GPs, residents and families.
- **Support residents' usual GP to provide comprehensive and coordinated continuity of care:** Support GPs with care and PPE guidelines and PPE, develop systems for secondary referral and advice, assist facilities in developing mechanisms for telehealth and pathways and protocols for care escalation, communication and clinical handover.
- **Support transitions of care between RACFs and hospitals:** Support GPs to provide up to date clinical and medication management and support patient's goals of care and any ACDs made, recognising that transitions of care are high risk points for medication errors and unclear or insufficient clinical handovers. Support the repatriation of residents back to their RACF after hospitalisation.
- **Support handover of care between GPs:** Work with local PHNs to identify additional primary healthcare workforce where required. Where care by the usual GP is not feasible, development of pathways for care and clinical handover to other GP services.
- **Facilitate professional development and upskilling for GPs.**
- **Assist GPs with proactive and timely communications.**

Recommendations:

- **Approval and funding for a RACF GPLO and project management role and evaluate outcomes for improved coordination of care and medical services; and**
- **Recognise the importance of, and support a system of care, where each resident is provided with comprehensive GP care (e.g. by supporting the RACF GPLO position, incorporating GP expertise in clinical management groups, DoH leadership groups, and having Primary Health Networks (PHNs) support GPs with secondary referral and support.**

[37] PHN North Western Melbourne, Improving the Primary Care-led Health System Response to COVID-19 in Residential Aged Care Facilities, Sept 2020.
[38] PHN North Western Melbourne, Funding Proposal – Proof of Concept Plan for a General Practice Liaison Officer in Residential Aged Care, Draft 17 Sept 2020.
[39] PHN North Western Melbourne, Funding proposal – Proof of concept plan for a general practice liaison officer in residential aged care, Draft 17 Sept 2020.

Centre for Disease Control (CDC)

The COVID-19 pandemic has demonstrated the need for an independent body that incorporates all communicable disease functions that currently sit with different areas of Government.

Recommendations:

- **The establishment of a CDC that would:**
  - **enable Australia to have a national focus on current and emerging communicable disease threats, and to engage in global health surveillance, health security, epidemiology, research and evidence-based policy making;**
  - **manage pandemic threats in a more co-ordinated manner, and be better prepared for future outbreaks;**
  - **direct the policy and provide general guidance and direction in any future potential outbreaks in RACFs; and**
  - **eliminate some of the overlaps and inefficiencies from the lack of coordination between the Federal and State/Territory administrations.**

Learning from overseas experiences

Canadian research[40] found that people living in long-term care (LTC) were far more likely to die from COVID-19. However, this varied across provinces, including Ontario and British Columbia (BC), with many more residents in Ontario dying from COVID-19 than those in BC. Key differences were that before the pandemic the LTC system in BC exhibited a number of potential strengths relevant to pandemic preparedness compared with Ontario. There was:

- better coordination between LTC, public health and hospitals;
- greater funding of LTC;
- more care hours for residents;
- fewer shared rooms;
- more non-profit facility ownership;
- more comprehensive inspections; and
- BC was faster than Ontario in responding to COVID-19, with actions to address public health support, staffing and infection prevention and control; and, leaders in BC were more decisive, coordinated and consistent in their overall communication and response.

Recommendation:

- **Examination of the overseas experience in dealing with the COVID-19 Pandemic in RACFs to inform current and future planning.**

Risk rating

The outbreaks in Victoria exacerbated the significant deficiencies of the aged care system and the lack of coordination between Federal, State and Territory governments. There is an urgent need for a coordinated proactive risk assessment and plan for all RACFs Australia-wide.

Risk assessments need to incorporate the potential impact of infected and isolated staff, triggers for transfer and transfer destinations; and, the identification of appropriate facilities where COVID-positive residents who do not need acute healthcare, could be evacuated to in the short term.

Due to concern about lack of preparedness of some residential aged care facilities, Victorian Directors of Nursing made the decision to take it upon themselves to risk rate the RACFs in their health hubs to determine their potential vulnerability to an outbreak during the pandemic, their relationship to existing clinical services and organisational capacity to respond.

The Committee developed the '*Residential Aged Care COVID Risk Screen'*. This tool assesses risks to residents such as: the number of residents; number of shared rooms and common areas; whether any residents or staff have COVID-19 symptom, whether the facility has a pandemic plan and PPE training undertaken; adequate stocks of PPE; advance care plans in place; contingency plans in case of 40% staff absence; and, whether staff work in other facilities. The risk rating

[40] Liu, M. et al, CMAJ 2020, doi: 10.1503/cmaj.201860, early release 30 September 2020

applied then allowed the EDONs to identify which facilities would be most at risk. This then informed decision making and prioritisation of resources.

In evidence to the ACRC, Professor Joe Ibrahim stated that data held by the Aged Care Quality and Safety Commission and the Commonwealth Department of Health as part of their usual reporting processes could be used to identify risk factors, such as accreditation audit, hospital utilisation, and, Aged Care Funding Instrument (ACFI) data such as:

- Resident vulnerability: using age, persons with dementia, level of care classification
- RACF vulnerability: number of residents, provider's performance in terms of meeting the quality standards and complaints, physical environment
- Organisational response capability: geographical proximity of RACFs to public hospitals, staffing levels, utilisation of acute hospital emergency departments in past 12 months acute health resources in the region and the general practitioner to population ratio.

The information could be collated and used to develop a risk register according to each profile of every RACF. There is currently sufficient data collected to enable this to occur.[41]

We also need to look at what could happen upstream and prior to an outbreak, such as the capacity to have an infection control professional linked to the facility earlier to help with planning and the setup of an 'outbreak management team'. The Department of Health (DoH) should have a living record of who is on the 'outbreak management team' reported by each facility.

Recommendations:

- **An urgent national audit of RACFs to identify and prioritise risks and, the organisation's capability to respond using existing information. This would identify those most vulnerable and least equipped to manage should an outbreak occur; and**
- **Assess the ability of all RACFs to safely cohort residents and the capacity to provide a safe environment.**

Telehealth for RACF residents

As many aged care residents have complex needs, the provision of medical care can be difficult by solely electronic means, particularly with a frail resident unwell with COVID-19. While a face-to-face consultation is preferred, that is not always going to be possible during a pandemic.

The Federal AMA played a key role in brokering expanded telehealth access to GPs and other medical specialists that allowed for continuation of normal patient care and reduced the need for scarce PPE.

Post-pandemic GP telehealth services should be expanded to cover services doctors are already providing to patients in RACFs.

Based on the lessons learned from the pandemic, the AMA has now expanded this to include non-GP specialists, such as psychiatrists and geriatric medicine specialists. Telehealth provision of mental health care may be an essential support during physical distancing and isolation.

Recommendation:

- **Introduce an MBS telehealth item for telehealth between the GP, RACF staff and relatives; and**
- **The Government should consider undertaking a pilot of telehealth for RACFs for afterhours consultations. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision-making.**

Training of aged care staff

While the Department of Health should be commended for quickly developing online training resources for aged care staff, training *during* a pandemic is not the preferred approach. Staff should have already been trained and prepared to manage an outbreak and then provided with refresher training once the threat arose. It is the requirement of the Aged Care Quality Standards to minimise infection risks.

Influenza outbreaks happen annually in Australia, and it is often the elderly that are most affected. Although COVID-19 estimates show a higher transmission and case fatality ratio than seasonal influenza, the training that the aged care

[41] https://agedcare.royalcommission.gov.au/system/files/2020-08/RCD.9999.0411.0001.pdf

staff should have had before this pandemic, including training to meet Standard 3 to prevent and control infection, would have better prepared them.

Recommendation:

- **Infection prevention and control training should be a core component of induction of anyone starting work in RACFs. Continuous training refreshers and competency audits for RACF staff should also be required and facilitated.**

Improved palliative care guidelines for RACFs

Palliative care physicians have noted that RACFs were variable in their palliative care ability. Issues noted are that there was poor access to urgently required medications and a significant knowledge gap. In response to this, one hospital linked experienced palliative care nurses to the RiR teams and arranged for them to have their own imprest stocks. The experienced palliative care nurses were able to have many skilled conversations with families (due to cognitive impairment of the resident) and prepared them for impending death. This was very much valued by the families, some of whom had been unable to visit their family member for months.

In the event that palliative care is required, one AMA member stated that in the event of a pandemic those residents wishing no transfer are not moved to hospital, but could be moved to a COVID-19 area within their facility: '*These residents are in the end stage of their lives and transfer from familiar surroundings and faces, who have become their family over their stay, would be devastating. This was apparent at a private hospital where confused aged care residents were managed by unfamiliar nursing and personal care staff and doctors. Ideally, palliative care residents would be managed in COVID-19 positive sections of their facilities - with extra well-trained staff.*'

However, as it stands, a RACF cannot simply ring a community palliative care team and expect immediate assistance. There is a process in which a referral is made, referral accepted, first visit undertaken and then the community palliative care (CPC) team can give assistance. Moreover, a CPC won't manage a patient unknown to their service, but they will manage patients known to their service. In most states, there are phone lines that can be used straight away to give advice as a bridge to CPC referral, including in Victoria.

Recommendations:

- **Improve the palliative care guidelines for COVID-19 positive residents recognising the work that the Australian & New Zealand Society of Palliative Medicine (ANZSPM) has already undertaken in this area;**
- **Ensure that RACFs have adequate staffing and supplies of palliative medicine available including provision of adequate subcutaneous medications to RACFs residents by nurses who are trained to administer it;**
- **Increase the number of RNs with palliative care skills in RACFs; and**
- **Reinforce the linkage and provision of care by community palliative care services.**

Support and follow-up for staff, residents and families involved in outbreaks

A recent New Zealand independent review of COVID-19 residential aged care clusters found that there was a significant psychological burden placed on staff.[42] There have been similar concerns raised by Australian aged care providers and staff.

Many AMA Victoria members are concerned about the impact of the COVID-19 outbreaks on RACFs and multidisciplinary emergency response staff, in addition to residents and their families. Many have experienced significant trauma.

There was also a psychological toll on staff having to also manage the interactions with families and media – particularly in interpreting and applying restrictions which were often conflicting, or were inconsistent as between Federal and State government departments, in the face of media scrutiny and family complaints and concern.

Recommendation:

Monitoring for adverse impact on RACF staff and provision of appropriate support where required should be immediately implemented.

[42] https://www.health.govt.nz/publication/independent-review-covid-19-clusters-aged-residential-care-facilities