



**Royal
Commission
into Aged
Care Quality
and Safety**

**Aged care
and COVID-19:
a special report**



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Royal Commission
into Aged Care Quality and Safety

30 September 2020

His Excellency General the Honourable David Hurley AC DSC (Retd)
Governor-General of the Commonwealth of Australia
Government House
CANBERRA ACT 2600

Your Excellency

In accordance with the Letters Patent issued on 6 December 2018, as amended on 13 September 2019 and 25 June 2020, we are making inquiries, and preparing the Final Report of the Royal Commission into Aged Care Quality and Safety.

From 10 to 13 August 2020, we held a hearing as part of our investigation of the response to COVID-19 in aged care. We now submit to you a special report on that response.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Gaetano Pagone'.

The Honourable Gaetano (Tony) Pagone QC

A handwritten signature in blue ink, appearing to read 'Lynelle Briggs'.

Ms Lynelle Briggs AO

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Aged care and COVID-19: a special report

From 10 to 13 August 2020 we held a hearing as part of our investigation into the response to COVID-19 in aged care. We are greatly indebted to the many people—including people receiving aged care services and their loved ones, some of whom were recently bereaved—who shared with us their stories and experiences, both at the hearing and by making written submissions.

We heard evidence of the effect of the pandemic on those working in aged care. The Interim Report noted that the aged care workforce is under-resourced and overworked.¹ It is now also traumatised.² Care workers develop close relationships with residents. Many are grieving for residents who have died after contracting COVID-19. Others are anxious about bringing the virus into their work place or home to their loved ones.³ We pay tribute to aged care workers and to the vital work they do.

In addition, many people and organisations assisted in and cooperated with our investigation. The Australian Department of Health and its officials; the Aged Care Quality and Safety Commission and its officials; State health departments, including New South Wales (NSW), Victoria and South Australia, and their officials; and aged care providers all engaged in our processes in good faith. They provided access to documents, information and witnesses at a time when they were under considerable strain and public pressure. For this we are grateful.

1. Introduction and overview

Coronavirus disease is caused by the severe acute respiratory syndrome coronavirus 2. It was first identified in December 2019 and is a novel virus about which understanding is evolving. The World Health Organization (WHO) declared the novel coronavirus a ‘public health emergency of international concern’ on 30 January 2020. In February 2020, it named the disease caused by the virus ‘COVID-19’. On 11 March 2020, COVID-19 was declared a pandemic by the WHO.⁴

COVID-19 presents particular risks to older people, who are particularly vulnerable to respiratory diseases.⁵ In May 2020, the United Nations reported on the ‘devastating toll’ that the spread of COVID-19 in care homes was having on older people’s lives.⁶

Never before has the aged care sector in Australia faced a challenge like COVID-19. As at 19 September 2020, 844 people have died in Australia as a result of the virus. Of these, 629 were living in aged care homes at the time of their deaths, although many died in hospital.⁷

As at 2 September 2020, the overall Australian mortality rate from COVID-19 was 2.6%.⁸ This case fatality rate, as it is known, is low by international standards.⁹ For example, the equivalent rate in France is 13.6%; in the United Kingdom it is 12.8%; and in the United States it is 3.1%. However, as at 19 September 2020, the proportion of those Australians who have died and who were living in residential aged care facilities at the time of their deaths is approximately 74%, a high figure by international standards.¹⁰

Caution must be exercised when comparing care home-related death rates in different countries. This is because of the way data is collected and recorded and because the definition of what is a care home varies between countries.¹¹ One international study suggests that due to these factors:

to look at the relative impact of COVID-19 on care home residents in different countries, it is more useful to focus on the share of care home residents whose deaths have been linked to COVID-19.¹²

On this measure, Australia has performed relatively well, with a mortality rate of 0.25%. This is considerably lower than the rates in other comparable countries such as Canada (1.5%) and the United Kingdom (5.3%).¹³

The tragic impacts of the virus have been felt across the nation. An event such as this pandemic, and the consequential social, economic, and day-to-day life impacts, are beyond anything in the living memory of most in this country, with the exception of those people who were born before or during the Second World War.

The Australian Government is responsible for 'aged care services', as defined in our Letters Patent.¹⁴ The development and implementation of aged care policy, including advising the Australian Government, funding and administration are the domain of the Australian Department of Health. The Aged Care Quality and Safety Commission is responsible for aged care regulation. State and Territory Governments, together with the private sector, are largely responsible for the delivery of health care, including to those living in residential aged care. They also have overall responsibility for managing public health emergencies. Under the *Aged Care Act 1997* (Cth), aged care providers are responsible and accountable for providing quality care in a manner that complies with the Aged Care Quality Standards set out in the *Quality of Care Principles 2014* (Cth) made under the Act.¹⁵

When the Prime Minister announced this Royal Commission in 2018, nobody could have foreseen that the aged care sector would find itself in the grips of a pandemic as we approach the end of our work. Like others, we have had to respond to the changes brought about by the pandemic. This includes releasing this brief report in advance of our Final Report, which will be delivered on 26 February 2021. We do this now because we do not know how long the pandemic will last. Its end is impossible to predict. However, aged care residents continue to suffer and, tragically, some more may die as a result of COVID-19.

It is clear to us that people receiving aged care services, their loved ones, those providing care and the aged care sector itself need immediate support and action. Governments need guidance based on the evidence we have heard and are able to summarise in this report.

At the time we announced our inquiry on 17 May 2020 into the response to COVID-19 in aged care, outbreaks had struck three homes in suburbs of Sydney, NSW: Dorothy Henderson Lodge, a home run by BaptistCare NSW & ACT (BaptistCare) in Macquarie Park; Opal Bankstown; and Newmarch House, a home run by Anglican Community Services (Anglicare Sydney) in Kingswood. By the time our hearing commenced on 10 August 2020, a major outbreak of the virus had taken hold in Victoria, with dozens of facilities experiencing outbreaks, 1221 infections among residents of aged care facilities, and, tragically, 189 deaths of residents. Even while the hearing unfolded, further deaths and infections associated with residential aged care were announced daily.

Now is not the time for blame. There is too much at stake. We are left in no doubt that people, governments and government departments have worked tirelessly to avert, contain and respond to this human tragedy.¹⁶ However, the nation needs to know what lessons have been and can still be learnt. The nation needs to know what is being done, and what will be done, to protect those people receiving aged care services—those who this virus has affected disproportionately and whose entitlement to high quality care in safe environments that protect their wellbeing and dignity falls within the scope of our commission.¹⁷

In the weeks leading up to our hearing there were calls for us to conduct a full inquiry into the impact of COVID-19 on aged care, including into the situation that was unfolding in Victoria. We explained at that time that we did not have the resources or time to conduct such an inquiry. We remain of that view. Whether there is to be a full inquiry into these matters is for governments to decide. It is not for us as serving Commissioners with a broader task to be completed by a fixed date to do so.

In the confines of the inquiry we were able to conduct, we have concluded that there are four areas where immediate action can and should be taken to support the aged care sector:

- First, the Australian Government should fund providers to ensure there are adequate staff available to deal with external visitors so that the *Industry Code for Visiting Residential Aged Care Homes during COVID-19* (Visitation Code) can be modified to enable a greater number of more meaningful visits between people receiving care and their loved ones.
- Second, the Australian Government should create Medicare Benefits Schedule items to increase the provision of allied health and mental health services to people living in residential aged care during the pandemic to prevent deterioration in their physical and mental health. Any barriers, whether real or perceived, to allied health and mental health professionals being able to enter residential aged care facilities should be removed unless justified on genuine public health grounds.
- Third, the Australian Government should publish a national aged care plan for COVID-19 and establish a national aged care advisory body.
- Finally, the Australian Government should arrange for the deployment of accredited infection prevention and control experts into residential aged care homes.

COVID-19 is a public health crisis that has disproportionately affected aged care in Australia. Much was made during the hearing of whether there was an aged care-specific plan for COVID-19. There was not a COVID-19 plan devoted solely to aged care. But there was a national COVID-19 plan that the Australian Government sought to adapt and apply to the aged care sector. That plan, the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (Health Sector Plan), was developed in January 2020 and published on 18 February 2020. On 27 February 2020 it was activated by the Prime Minister in anticipation of a pandemic.¹⁸ The Health Sector Plan was developed against the background of the National Health Emergency Response Arrangements which had been in place since 2011 and provided a ‘whole-of-government response to significant national health emergencies, including pandemics’.¹⁹

The Health Sector Plan was drawn to the attention of aged care providers in a letter from Professor Brendan Murphy, then the Australian Chief Medical Officer, that was published on the Australian Department of Health’s website on 27 February 2020. In the letter, Professor Murphy told providers the Health Sector Plan was a ‘useful reference tool for preparing your emergency plan, particularly with respect to pandemic infections’.²⁰

The Health Sector Plan was augmented by a range of guidelines and material that was disseminated to aged care providers in the period from March to August 2020.²¹ During this period, the Australian Department of Health and the Aged Care Quality and Safety Commission were active in assisting the aged care sector to prepare for and respond to the pandemic.²² The Australian Government has ‘committed over \$1.5 billion of additional funding measures to support aged care preparedness and response’ in 2020.²³ The Government is to be commended for these initiatives.

Early in 2020, both the Australian Department of Health and the Aged Care Quality and Safety Commission established taskforces dedicated to COVID-19. The role of the Commission’s taskforce was to manage strategic and operational issues in relation to COVID-19, responding ‘as required to issues or needs which arise, quickly and flexibly’.²⁴ The Australian Department of Health’s taskforce was established to lead ‘the aged care response to the pandemic’.²⁵

On 2 March 2020, the Aged Care Quality and Safety Commissioner, Ms Janet Anderson PSM, wrote to aged care service providers to give them ‘updated advice’ on COVID-19. Ms Anderson told providers they should pay close attention to the Aged Care Quality Standards and urged them to undertake self-assessment. An attachment to the letter contained a list of ‘links to useful resources’ on the Australian Department of Health’s website. Ms Anderson warned, in her letter, that while COVID-19 cases were then low in Australia, the ‘situation could change at any time, and providers of all services need to give a high priority to planning’ for such a scenario.²⁶

Ms Anderson’s advice was portentous. Unbeknownst to her or any others, the very next day the first COVID-19 outbreak in residential aged care in Australia would begin. On 3 March 2020, a personal care worker at Dorothy Henderson Lodge in Sydney was diagnosed with COVID-19. By 6 March 2020, four residents and two more staff members tested positive. On 7 May 2020, the outbreak was declared to be over.

By this time, 16 of the 80 residents (20%) and five staff members had tested positive. Six of the 16 residents diagnosed with COVID-19 died during the outbreak, a mortality rate of 37.5%. The staff members have since recovered.²⁷

On 13 March 2020, two days after the WHO had declared the pandemic, the Communicable Diseases Network Australia (CDNA) released its *National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia* (CDNA Guidelines).²⁸ The CDNA Guidelines were updated on 30 April 2020 and on 14 July 2020.²⁹ Professor Murphy described these guidelines as ‘the fundamental foundational plan’.³⁰ We discuss the CDNA and the CDNA Guidelines below.

Between 17 and 26 March 2020, the Aged Care Quality and Safety Commission conducted ‘assessment contacts by telephone’ with residential care providers to ‘monitor and support their preparation for a COVID-19 outbreak’.³¹ In a letter dated 4 May 2020 to our staff, Ms Anderson explained that during these contact calls, providers were reminded of their responsibilities under the Standards in relation to infection control, and providers’ attention was drawn to the CDNA Guidelines.³²

The Aged Care Quality and Safety Commission also developed an online self-assessment survey to ‘support approved providers’ to review their infection control systems and to evaluate their preparedness for a COVID-19 outbreak.³³ Virtually all (99.5%) of providers claimed that their infection control / respiratory outbreak management plan covered all areas identified in the survey. The same proportion assessed their service’s readiness in the event of a COVID-19 outbreak as either satisfactory (56.8%) or best practice (42.7%).³⁴

On 23 March 2020, a resident at Opal Aged Care’s Bankstown residential facility who was already a hospital inpatient was diagnosed with COVID-19. Two further residents who tested positive were transferred to hospital. There were no further cases of COVID-19 at Opal Bankstown. Jonathan Anderson, Opal Aged Care’s NSW South Regional General Manager, considered that this successful response to the outbreak was due to the preparation work that Opal had done including ‘command and control structures’ which had been implemented during the response to the NSW bushfires in December 2019 and January 2020.³⁵

On 11 April 2020, a staff member at Anglicare Sydney’s Newmarch House was diagnosed with COVID-19. By the time the outbreak was declared over on 15 June 2020, 37 of the 97 residents (38%) and 34 staff members had tested positive. Seventeen deaths ‘were directly attributed to COVID-19’, a mortality rate of 46% of the COVID-19 positive residents at Newmarch House.³⁶ The staff members have since recovered.³⁷

Anglicare Sydney had used the CDNA Guidelines as a model for its COVID-19 preparation at Newmarch House and its 21 other homes.³⁸ On 24 March 2020, Newmarch House completed the Aged Care Quality and Safety Commission’s online self-assessment survey and assessed its readiness for a COVID-19 outbreak as ‘best practice’.³⁹ Ms Erica Roy, Anglicare Sydney’s Manager of Service Development and Practical Governance, oversaw the self-assessment and told us that, with the benefit of hindsight, the assessment was not accurate.⁴⁰ In part, this was because Newmarch House’s preparedness self-assessment was based on the CDNA Guidelines.

These, Ms Roy said, caused Newmarch to treat COVID-19 ‘as a flu-like illness’ when in reality it had ‘a lot more of an impact’.⁴¹ Further, Ms Roy explained that having ‘the use of an infection prevention specialist on the ground would be something that would be best practice in my eyes now’.⁴²

On 22 August 2020, the Australian Health Protection Principal Committee (AHPPC) released a statement that listed ‘key national statements and guidelines’ relevant to aged care that it had reviewed and authorised. It went on to provide links to eight ‘key national statements and guidelines’.⁴³ This is a positive development that brings together the disparate guidelines and recommendations and draws them to the attention of the aged care sector. It is a useful framework for the national aged care plan for COVID-19 that we recommend be developed.

Our recommendations and reasons for them are set out in detail below. Our first recommendation is that the Australian Government report to Parliament on the implementation of the remaining five recommendations. The recommendations we make are important and the public has a right to know how the Government has responded to them.

Recommendation 1

The Australian Government should report to Parliament by no later than 1 December 2020 on the implementation of these recommendations.

2. Visitors and quality of life

Recommendation 2

The Australian Government should immediately fund providers that apply for funding to ensure there are adequate staff available to allow continued visits to people living in residential aged care by their families and friends.

We begin with the measures necessary to restore physical connection between older people in aged care homes and their families and friends. We do so because older people must always be at the heart of the aged care sector and of any response to any event affecting their physical and mental wellbeing. Systems and plans are, of course, important, but they should always be linked to the object of protection. The aim of providing real, tangible and meaningful assistance to people must be our primary, overriding and constant focus. The understandable restriction of visits between older people and their friends and families has had tragic, irreparable and lasting effects which must immediately be addressed as much as possible.

Visits from family and friends are critical to the physical, mental and emotional health and wellbeing of people living in residential aged care and also their friends and families. The benefit of such visits cannot be wholly replaced by technology.

UY

UY's father was an Italian man with motor neurone disease who had been living in residential aged care since June 2019. He was non-verbal and relied on physical touch to communicate. His facility went into lockdown in March 2020 due to COVID-19. This meant that UY could no longer hug or touch her father, or hold his hand for walks around the grounds of the facility. UY said that her father could not understand why he could no longer touch and hug his family, and deteriorated rapidly. She said:

I believe that during this time, love was not the biggest priority, but enforcing the system was. I felt that all that had been promised when Dad entered the nursing home had changed.⁴⁴

On 6 June 2020, UY's father went to sleep and did not wake up again. He died on 13 June. Of his death, UY said:

I believe Dad gave up wanting to live because his family support and connection was disconnected. As an Italian man, he had lost what he called his 'blood support'. Without this, he did not have meaning.⁴⁵

UY told us that she believed her dad needed connection, and that he deteriorated because it was denied to him:

A nursing home can never be what a family is to someone. It will never fill the gap, but it is a tool to help families with their loved ones. It will never replace the love and connection a family can give to loved ones, and it should not assume that it has the right and authority to do that.⁴⁶

The States and Territories have issued public health directions which have impacted on visitors to aged care homes. Generally speaking, these have limited 'care and support' visits to one per day.⁴⁷ Sometimes, these directions have restricted visits altogether. For example, in late August 2020, NSW Health requested residents of the Sydney Metropolitan and Central Coast areas refrain from visiting residential aged care homes during a period of increased community transmission; and on 18 September 2020, the Victorian Premier foreshadowed that visiting aged care homes in Victoria would not return to normal until well into 2021, while recognising that there is a balance to be struck. Aged care providers have imposed restrictions in line with State and Territory directions. Some providers have elected to impose stricter restrictions on visitation rights in an attempt to halt the spread of COVID-19.

While many residents of aged care homes have not experienced a COVID-19 outbreak at their facility, they have endured restrictions for most of this year that go beyond those endured by the general community.

As a consequence, many have not been able to spend time with their loved ones in a meaningful and fulfilling way. Although there have been attempts by both the aged care sector and the Australian Department of Health to improve this situation, those attempts have been inadequate partly because of a lack of funding for additional staff to facilitate visits by conducting screening, assisting with personal protective equipment (PPE) and, where necessary, accompanying visitors.

The reduction in visitors means that staff time is stretched just trying to meet the day-to-day care needs of residents.⁴⁸ Some providers have increased staff numbers to meet these additional needs. But many providers, according to the evidence of union surveys, have reduced staff numbers.⁴⁹ This deficiency must be addressed urgently.

Maintaining the quality of life of those people living in residential aged care throughout the pandemic is just as important as preparing for and responding to outbreaks. Residents' entitlement to quality of life does not change in an emergency, although how this can be achieved does. If anything, quality of life becomes more important. For many residents of aged care homes, the restrictions on visits have had, and will continue to have, serious consequences. Ms Merle Mitchell AM acknowledged the success of her facility in keeping the virus out, but asked 'at what cost?'.⁵⁰

Visits from family and friends are not just matters of lifestyle. Visits are also an integral part of health, enablement and happiness. Visitors often provide part of the care and support which is needed by older people in aged care homes.⁵¹ The time spent with them by their friends and relatives inevitably includes time spent in conversation, exercise, and assisting them to eat and drink, as well as maintaining continuing connection with life and the community. Informal carers, often family members who supplement the care provided in aged care homes, also play a critical role as the 'eyes and ears'—monitoring the quality of care their loved ones receive.⁵²

Whether family and friends can visit aged care homes has been a contested issue since the first cases of COVID-19 in Australia. On 11 May 2020, the issue was addressed through the Visitation Code, which was developed and endorsed by several peak organisations representing aged care providers, older people and carers.⁵³ That code has been the subject of three reviews. It is not binding. The third version of the CDNA Guidelines acknowledges the likelihood that protracted restrictions on visitation will have 'detrimental impacts' on the wellbeing of residents. It notes the 'vital importance' of residents' personal welfare and mental health, in which visitors play an important role.⁵⁴

COVID-19 has seen a large increase in depression, anxiety and confusion in residents. The risk of suicide in residential aged care has increased.⁵⁵ Ms Julie Kelly, a psychologist, said that 'for a lot of the residents, there's a real, real strong sense of hopelessness, of not knowing when this is going to end or being able to see any changes for them'.⁵⁶

There is a balance to be struck between limiting the likelihood of an outbreak of COVID-19 and ensuring residents can receive visitors.⁵⁷ The evidence we have heard makes clear that more can be done to enable older people in aged care homes to have greater access to their friends and families where this can occur without appreciable risk.

Providers described a number of the measures which they have implemented to strike a better balance than that in the Visitation Code between taking precautions against COVID-19 while maintaining other parts of life that contribute to the health and happiness of residents. Initiatives included:

- a concierge service to coordinate and screen visitors⁵⁸
- walking programs and active and passive in-room exercise programs⁵⁹
- dedicated communications teams within facilities to improve coordination between residents and their families⁶⁰
- training programs for family members in infection control and the use of PPE to continue to ensure safety of visits.⁶¹

Such initiatives are dependent upon adequate staffing and therefore require additional resources. Ms Annie Butler of the Australian Nursing and Midwifery Federation and Ms Carolyn Smith of the United Workers Union pointed to a lack of acknowledgement of the increased staffing numbers required to support the measures in the Visitation Code.⁶² They complained that they and their members had not been consulted in the development of the Code.⁶³ In submissions filed after the hearing, COTA Australia, the national consumer peak body for older Australians, pointed out that, while it was correct that the unions had not been involved in the preparation of the initial draft, the Australian Nursing and Midwifery Federation was given one week to comment on the draft.⁶⁴ The aged care workforce and its representatives should not be excluded from any future refinement of the Visitation Code.

Funding to support increased visits is needed immediately. Providers should not be left to divert staff to facilitate such measures from the care and other activities that residents require and which staff must perform.⁶⁵ During the pandemic, additional funding is needed for staff dedicated to those activities in order to facilitate access of visitors to the homes in which older people are living. Any provider that commits to employing additional staff for this purpose should receive reasonable funds from the Australian Department of Health to assist it to do so. There should be a simple application process.

Providers must continually review and revise their position on visitation, recognising the particular circumstances of their facility and the level of community transmission in their location. The sector must be encouraged to share and celebrate innovative solutions. Aged care providers, the Australian Department of Health, and the States and Territories must make every effort to encourage and facilitate safe visitation that complies with State and Territory public health restrictions. These visitations should be humane and proportionate to risk, even during periods of community transmission. In all but extreme cases, blanket bans on visitation are unacceptable and should be both explained and justified.

We note that Mr Michael Lye, Deputy Secretary for Ageing and Aged Care in the Australian Department of Health, specifically said, when giving evidence, that he was not aware of any cases where visitation has resulted in a case of COVID-19 within a facility.⁶⁶

The description of the places in which older people live as ‘their homes’ must be the reality and not just a description. To be a home, those living there should be able to enjoy all of the ordinary incidents of home living, including sharing their home with friends and relatives. They should certainly not find themselves in their more vulnerable days facing their fears of the pandemic without the comfort and support of their friends and families.

3. Allied health

Recommendation 3

The Australian Government should urgently create Medicare Benefits Schedule items to increase the provision of allied health services, including mental health services, to people in aged care during the pandemic. Any barriers, whether real or perceived, to allied health professionals being able to enter residential aged care facilities should be removed unless justified on genuine public health grounds.

COVID-19 restrictions have a negative impact on the health and wellbeing of residents living in aged care homes. To manage this impact, the Australian Government and providers should ensure residents have access to the additional services that they need.

Levels of depression, anxiety, confusion, loneliness and suicide risk among aged care residents have increased since March 2020.⁶⁷ Some of this can be attributed to missing family, changed routines, concern about catching the virus or fear of being isolated in their rooms.⁶⁸ In some cases, people living in aged care homes are no longer doing the incidental exercise they were previously doing.⁶⁹ Gerontological physiotherapist Mr Rik Dawson explained that reduced activity and mobility causes older frail people to ‘deteriorate very quickly’, losing their muscle strength which will rapidly lead to a loss of balance and increased falls.⁷⁰ We are well aware that falls can be the beginning of decline and death for people in aged care.

Allied health professionals told us that COVID-19-related restrictions have had an impact on their ability to provide services. Despite allied health professionals being exempt from those who are excluded from aged care homes, some residents of residential aged care have had their access to allied health professionals reduced at a time when there is an increased need for such services.⁷¹

There was variability in the way residential aged care facilities responded to the COVID-19 lockdowns imposed in March 2020, with some seeing allied health professionals as essential workers and others requesting that they return once the restrictions were lifted.⁷² The Visitation Code and State directives now make clear that allied health professionals are not to be considered visitors. While this has helped, there are still a number of residents who are not getting access to services because of the perceived risk of infection.⁷³ Any real or perceived barriers to allied health professionals accessing aged care homes to provide services must be removed unless they can be justified on genuine public health grounds due to the risks of infection in the community in which a home is located.

The Australian Government responded quickly to create Medicare Benefits Schedule items to increase mental health service access for people, including older people, living in the community.⁷⁴ Similar measures should be taken to increase the provision of allied health services, including mental health services, to aged care residents during the pandemic to prevent deterioration in physical and mental health. Providers should ensure they provide the fullest range of allied health services they can.

4. National advisory body and plan

The AHPPC is the key decision-making committee for health emergencies. The AHPPC is comprised of the Chief Health Officers of the States and Territories and is chaired by the Australian Chief Medical Officer.⁷⁵ Although the AHPPC draws on the expertise of other disciplines, such as emergency management and the Australian Defence Force, none of its members is an aged care specialist.⁷⁶

On 17 March 2020, the AHPPC released a statement on COVID-19, which directed the following comment to the aged care sector:

While all respiratory viruses can cause outbreaks and significant morbidity and mortality, COVID-19 is acknowledged as a significant health risk particularly for the elderly and individuals with co-morbidities or low immunity.⁷⁷

While the AHPPC acknowledged this significant issue, it is now clear that the measures implemented by the Australian Government on advice from the AHPPC were in some respects insufficient to ensure preparedness of the aged care sector.

Confused and inconsistent messaging from providers, the Australian Government, and State and Territory Governments emerged as themes in the submissions we have received on COVID-19. All too often, providers, care recipients and their families, and health workers did not have an answer to the critical question: who is in charge? At a time of crisis, such as this pandemic, clear leadership, direction and lines of communication are essential.

4.1 An aged care advisory body and a COVID-19 plan

While the Health Sector Plan and CDNA Guidelines discussed above are important documents, there is a clear need for a defined, consolidated, national aged care COVID-19 plan. That plan should be created by the national aged care advisory body which we propose below, having regard to the particular needs of the aged care sector.

Recommendation 4

The Australian Government should establish a national aged care plan for COVID-19 through the National Cabinet in consultation with the aged care sector.

This plan should:

- establish a national aged care advisory body
- establish protocols between the Australian Government and the States and Territories based on the NSW Protocol but having regard to jurisdictional differences
- maximise the ability for people living in aged care homes to have visitors and to maintain their links with family, friends and the community
- establish a mechanism for consultation with the aged care sector about use of Hospital in the Home programs in residential aged care
- establish protocols on who will decide about transfers to hospital of COVID-19 positive residents, having regard to the protocol proposed by Aged and Community Services Australia
- ensure that significant outbreaks in facilities are investigated by an independent expert to identify lessons that can be learnt. The results of any such investigations should be promptly disseminated to the sector.

Under the Health Sector Plan, the AHPPC is responsible, 'in consultation with relevant parties and on advice from expert bodies', for selecting which activities in that plan should be implemented.⁷⁸

There are five 'standing committees' overseen by the AHPPC, of which the Communicable Diseases Network Australia is one. The role of the Network is to provide 'national public health co-ordination and leadership, and support best practice for the prevention and control of communicable diseases'.⁷⁹ Most of its 24 members have public health and infectious diseases expertise, but none of them is an aged care specialist.⁸⁰

Each version of the CDNA Guidelines places primary responsibility for managing COVID-19 outbreaks in residential aged care on the aged care provider. They describe the advisory roles to be performed by the relevant State or Territory departments, and they describe the function of the Aged Care Quality and Safety Commission. The third version of the CDNA Guidelines dealt with the role of the Australian Department of Health in aged care.⁸¹ The Australian Government's role was described as being to 'work collaboratively with the overall management of the response to support the viability and capacity' of the provider 'to access services'.⁸²

The Australian Government commissioned an independent review of the Newmarch House outbreak. The reviewers, Professor Lyn Gilbert AO and Adjunct Professor Alan Lilly, said that at the outset of an outbreak, 'there must be a clear operating protocol in place, outlining the relevant stakeholders, their respective roles and the hierarchy of decision making'.⁸³ We agree. A national aged care COVID-19 plan developed and supported by the national aged care advisory body we propose would achieve this end.

This issue featured prominently in the evidence of Professor Joseph Ibrahim, specialist practitioner in geriatric medicine, who has been advocating for the creation of a national coordinating body specifically for residential aged care.⁸⁴ We have benefitted from Professor Ibrahim's analysis of the situation. However, the approach we recommend differs from his.

The existing standing committees of the AHPPC have played, and continue to play, a vital role in Australia's response to the pandemic. However, in our view, advice for government about the response to the pandemic in the aged care sector must be given by a dedicated national aged care advisory body. Such a body must have members with expertise in the following: aged care; health care, including clinical geriatric care; infection control as it applies in a 'home-like setting'; the operational requirements of a range of aged care settings; and the particular characteristics of the aged care workforce. Advice from such a body will enable the Australian Government to play the vital leadership role it must play as the Government with responsibility for the sector. The body must consider the needs and rights of those living in aged care and their families and friends. This dedicated body for aged care should fit within the existing AHPPC framework.

We note that the Australian Government recognised the need for such a body with expertise in aged care when on 21 August 2020 it announced the establishment of a 'time-limited AHPPC Aged Care Advisory Group'.⁸⁵ This time-limited group is chaired by Professor Michael Kidd, Deputy Chief Medical Officer, Australian Department of Health. Its membership includes people with expertise in geriatric care, primary care and infection control in aged care settings.⁸⁶

The establishment of this group is positive but does not go far enough and should not be time-limited. It is critical that there is a body responsible for monitoring and planning for health emergencies as they apply to the aged care sector. There is a need for a body with a particular focus on the group of people most vulnerable to this and other infectious diseases to provide regular and timely practical information to the aged care sector. The body we have in mind will have a role beyond the current pandemic. For example, it will assist the sector to prepare for future influenza outbreaks which lead to many deaths in homes each winter.

The Australian Government should establish a dedicated and ongoing aged care standing committee within the AHPPC structure.

4.2 Protocols between the Australian Government and the States and Territories

On 23 June 2020, the Australian Government, through the Australian Department of Health and the Aged Care Quality and Safety Commission, and the NSW Government, through the NSW Ministry of Health (NSW Health), formalised, through a protocol, the coordination of support to an aged care provider in its management of a COVID-19 outbreak in NSW (the NSW Protocol).⁸⁷ We note Counsel Assisting's submission that a document of this kind could have been prepared in February 2020 before any outbreak of COVID-19 in residential aged care but that it was only formalised after two such outbreaks had been declared to be over in NSW.

A lack of clarity of roles during the Newmarch House outbreak added to the complexity of the response. The independent reviewers of Newmarch House refer to the ‘dilemma’ faced by senior management at Newmarch House because of the dispute that had arisen between Australian Government officials and NSW Health officials about the transfer of residents to hospital. Dr Melanie Wroth, the Chief Medical Advisor of the Aged Care Quality and Safety Commission, recommended residents with COVID-19 be transferred to hospital. This proposal was ‘vehemently opposed’ by Dr James Branley, Director of Infectious Diseases at Nepean Hospital, who had been providing onsite clinical support at Newmarch House from the outset of the outbreak.⁸⁸

Dr Branley ended his involvement on 16 April 2020 because of the lack of clarity about:

- the respective roles of the Australian Government, the NSW Government and the provider
- who was making decisions regarding Newmarch House
- his own role.⁸⁹

Mr Grant Millard, Anglicare Sydney’s Chief Executive Officer, said that the inability to resolve the issue led to a ‘high degree of frustration’. He said that the impasse between the officials was only ‘in part resolved’ after he personally contacted and sought guidance from the Minister for Aged Care and Senior Australians, Senator Richard Colbeck, on 16 April 2020. Senator Colbeck told Mr Millard that he ‘understood the concern for role clarity’.⁹⁰ Ultimately, the NSW Health position prevailed when Mr Lye, the Deputy Secretary in Senator Colbeck’s department, ‘determined that Dr Branley would be responsible for clinical matters in Newmarch House’.⁹¹ Dr Branley was re-engaged as an advisor on 17 April 2020.⁹²

Ultimately, it was NSW Health’s responsibility to make the decision about whether residents would be transferred to hospital.⁹³ As we discuss below, NSW Health implemented its Hospital in the Home program at Newmarch House.

A protocol of the kind entered into between the Australian Government and NSW Health some two and a half months later would have avoided the confusion altogether and would have avoided unnecessary frustration to a provider that was already under considerable strain. A provider should not have to contact the Aged Care Minister to have an operational question answered.

The NSW Protocol sets out the roles and responsibilities of:

- the Australian Government
- aged care providers
- various NSW Government agencies.

The primary objectives of the NSW Protocol ‘are to optimise care for all residents’ of a residential aged care facility affected by COVID-19 ‘irrespective of their COVID-19 status’ and to ‘contain and control the outbreak to bring it to an end as quickly and as safely as possible’.⁹⁴ Dr Nigel Lyons, Deputy Secretary Health System Strategy and Planning in NSW Health, described the protocol as ‘good practice in how to facilitate fast mobilisation of required government support’ to an aged care facility experiencing a COVID-19 outbreak.⁹⁵ We agree.

When asked by Senior Counsel Assisting if it would be beneficial to implement protocols similar to the NSW Protocol between the Australian Government and other State or Territory Governments, Mr Lye explained that the CDNA Guidelines were the guiding principles and they set out the roles and responsibilities.⁹⁶

The NSW Protocol was shared by the Australian and NSW Governments with the Australian Health Ministers Advisory Council.⁹⁷ At the time of the hearing, comparable protocols, having regard to jurisdictional differences, had not been entered into between the Australian Government and other States and Territories. They should be.

Establishing protocols between the Australian Government and individual States and Territories is beneficial. Such protocols would leave no doubt about coordination arrangements. They would be valuable State or Territory-specific supplements to the aged care COVID-19 plan that we contemplate above.

4.3 The Victorian experience

By the time daily infection rates began to rise in the community in Victoria in mid-June 2020, Australia had experienced two significant COVID-19 outbreaks in residential aged care homes. It is unclear whether the lessons learnt from those outbreaks were shared widely before community transmission put people living and working in aged care in Victoria at risk.

From mid-June 2020, daily infection rates in Victoria began to rise from 20 cases on 16 June 2020 to 76 on 30 June 2020. It is unclear whether there was consideration of what these figures might mean for the aged care sector. Professor Mary-Louise McLaws, Professor of Epidemiology, Health Care, Infection and Infectious Diseases Control, University of New South Wales and a Consultant to the WHO, explained that ‘One or two cases as they started to increase in June should have been an alert that this is potentially a problem.’⁹⁸

The AHPPC released four statements directed to, or relevant to, the aged care sector between 12 March 2020 and 19 June 2020 but it provided no written guidance to the aged care sector in the period between 20 June 2020 and 3 August 2020.⁹⁹ During that time, the number of new daily infections in Victoria grew from 25 to 413 and the number of active cases in residential aged care facilities grew from zero to over 500.¹⁰⁰ It is of the utmost importance that governments and their advisers have the aged care sector uppermost in their considerations during periods of increasing community transmission of the virus or any other contagion due to the vulnerability of the residents. The dedicated advisory body we propose increases the likelihood of this occurring in future.

There were no active cases of COVID-19 in residential aged care before 7 July 2020 but by 13 July 2020 there were 28 cases. By 9 August 2020, the day before our hearing commenced, this figure exceeded 1000. The first recorded death of an aged care resident from COVID-19 in Victoria was on 11 July 2020. As at 13 September 2020, there have been 563 deaths.¹⁰¹

During this period, both the Australian Department of Health and the Aged Care Quality and Safety Commission were active in providing advice. However, this did not extend to mandating, or recommending, the use of face masks in aged care facilities. This is despite the fact that, according to Professor McLaws, masks are ‘a very cheap and effective method’ of slowing the spread of COVID-19.¹⁰²

On 29 June 2020, the Australian Department of Health released a document entitled *First 24 Hours – Managing COVID-19 in a residential aged care facility* (First 24 Hours Guideline).¹⁰³ This document provides critical guidance to facilities in the event they experience an outbreak. On 30 June 2020, the Aged Care Quality and Safety Commission issued a document directed to Victorian residential aged care services entitled *Covid-19: Are you alert and ready?* This document contained advice from the Commission’s Chief Clinical Advisor, Dr Melanie Wroth. It referred providers to the recently updated CDNA Guidelines.¹⁰⁴

On 7 July 2020, the Australian Government Minister for Aged Care and Senior Australians wrote to aged care providers urging them to ensure that their outbreak management plans were ‘up to date and ready to be activated’ but did not suggest that they should consider asking their employees to wear masks.¹⁰⁵

Two days after the first Victorian COVID-19-related death connected with aged care, on 13 July 2020, on advice from the AHPPC, the Australian Government Minister for Health announced that aged care staff working in Victoria’s lockdown zones (then Greater Melbourne and the Mitchell Shire) ‘will be required to wear surgical masks’.¹⁰⁶ This announcement came five weeks after the WHO advised that health workers should wear masks and four weeks after community transmission numbers in Victoria had started to increase in mid-June.¹⁰⁷

4.4 Hospital transfers and Hospital in the Home

Whether and in what circumstances a resident of an aged care facility who tests positive should be transferred to hospital is a matter that has received much attention both at the hearing and in public discourse. There are various factors that must be balanced in determining the best approach:

- the needs and preferences of residents diagnosed with COVID-19
- the needs of residents who have not contracted COVID-19 and their right not to be exposed to it
- the health and safety of those charged with caring for both sets of residents
- the risk of spread of the infection in all settings including in residential aged care and hospitals
- the impact on the broader health system.

Reflecting on the experience of the Hospital in the Home program at Newmarch House, Mr Millard told the Anglicare Sydney Board on 27 May 2020 that:

In the event of infection at another [Anglicare Sydney] home, Anglicare would be far more assertive regarding the most appropriate management of COVID-19 positive residents and would strongly push for these residents to be immediately transferred to hospital.¹⁰⁸

In evidence at the hearing, Mr Millard explained that the concern he expressed to the Board related to three matters that arose from Hospital in the Home. First, managing the risk of infection to other residents in the home. Second, the challenges of managing the infection to staff and others working with the residents.¹⁰⁹ Third, he said:

I believe that if we would have been able to transfer out COVID-positive residents earlier, we might have had an earlier liberalisation of what was, really, extremely difficult for our residents to go through being isolated in their rooms with the doors closed.¹¹⁰

As Ms Roy of Anglicare Sydney put it, 'They're a whole family in there and we need to treat each of them as important.'¹¹¹

A submission we received from BaptistCare Australia, in which the lessons of the Dorothy Henderson Lodge outbreak were discussed in very helpful detail, addressed this issue clearly:

Residential aged care homes are places where people live, assisted by staff to manage their chronic health conditions. They are designed to be as domestic and home-like as possible and they are not suitable places for treating serious cases of COVID-19. Suitable places are those capable of an extremely high level of clinical infection control which even hospitals are struggling with. Further, residential aged care providers have a duty of care to all residents...in the home.¹¹²

Views among experts and State health departments varied on the question of whether to hospitalise residents who test positive. Professor McLaws drew on WHO principles to explain that for aged care residents who are COVID-19 positive, 'Transfer to hospital is the only appropriate solution that may improve their survival rate and reduce the risk of infection in the remainder of residents.'¹¹³

South Australia has an automatic transfer policy under which a resident who tests positive to COVID-19 'will be transferred immediately to hospital by ambulance'.¹¹⁴ It also has a dedicated COVID-19 hospital.¹¹⁵ The policy was informed by the WHO's investigation of how China has managed the pandemic.¹¹⁶ Professor Spurrier explained that the policy requires the resident who has tested positive to 'go to the safest place in terms of not spreading the disease any further to other vulnerable residents in that home'.¹¹⁷

The policy is an application of the ‘population focused principle’ which requires public health decisions to be made to protect and improve the health of the community as a whole while considering the health of individuals.¹¹⁸ Professor Spurrier also explained the importance to public health decision-making of the ‘precautionary principle’, under which, as the *Public Health and Wellbeing Act 2018* (Vic) puts it, ‘if a public health risk poses a serious threat, lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk’.¹¹⁹

Dr Lyons of NSW Health explained that in NSW, ‘decisions in relation to the location of care and the separation of residents must be made on a case-by-case basis depending on the circumstances of the residents’ and the residential aged care facility.¹²⁰

The current version of the CDNA Guidelines are silent on the question. This is in contrast to the first two versions of the guidelines which advised that residents should be transferred ‘only if their condition warrants’.¹²¹ The Australian Government submitted that the omission of this advice in the current version of the CDNA Guidelines ‘does not reflect a particular policy of the Commonwealth that approved providers should cohort residents within a facility in a COVID-19 outbreak or that all COVID-19 affected residents should automatically be transferred to hospital’.¹²² ‘Cohort’ and ‘cohorting’ were terms used by a number of the witnesses to refer to separating residents who are COVID-19 positive from those who are COVID-19 negative.

Dorothy Henderson Lodge followed a policy in the early stages of the outbreak of transferring residents who tested positive to COVID-19 to hospital. However, later in the response ‘admission to hospital was not guaranteed with the decision made by MoH [NSW Health] on a case by case basis’.¹²³

Newmarch House residents, on the other hand, were generally treated at the facility under the Hospital in the Home program.¹²⁴ The prevailing view among the medical staff and government officials at that time was that ‘cohorting’ at the home would be preferred to hospital transfer unless such transfer was clinically necessary. Mr Millard told us that two residents were transferred to hospital. However, the NSW Health response to the independent report into Newmarch House states that seven residents were transferred to hospital.¹²⁵ NSW Health’s Hospital in the Home program is a substitute for in-hospital care. Under the program, instead of being admitted to hospital, a person who satisfies the criteria for hospital admission is ‘admitted’ to receive hospital-level care in their home.¹²⁶

NSW Health’s guideline, entitled *Adult and Paediatric Hospital in the Home Guideline*, details various requirements that need to be in place for Hospital in the Home to be implemented in aged care settings. These include a written agreement setting out the roles and responsibilities as well as the training and support for aged care home staff.¹²⁷ Both Mr Millard and Ms Roy spoke of their experience of Hospital in the Home at Newmarch House. While Dr Branley provided an overview of Hospital in the Home at a meeting with representatives of Anglicare Sydney and the Australian and NSW Governments on 16 April 2020, no written agreement of the kind contemplated in the policy was put in place before Hospital in the Home arrangements were implemented the following day. Ms Roy said such an agreement, together with training for staff, would have been useful.¹²⁸

On 4 August 2020, NSW Health's Agency for Clinical Innovation released a guideline entitled *Caring for adults with COVID-19 in the home*.¹²⁹ This document was prepared without consultation with those who had recent experience of Hospital in the Home and without consultation with the aged care sector more generally. NSW Health has since advised that consultations on amendments and future versions will involve the aged care sector.¹³⁰ We commend this.

Virginia Clarke

Virginia Clarke's father had been a resident at Newmarch House since 2013. Ms Clarke was generally happy with the communication from Newmarch House until March 2020 when the facility went into lockdown due to COVID-19. After an outbreak on Easter Sunday, Ms Clarke received a phone call to say all residents, including her father, would be tested for COVID-19. Despite calling multiple times the following week, Ms Clarke only found out by accident that her father had tested positive on Friday 17 April 2020. On Sunday 19 April, he died in the facility. Of this experience, Ms Clarke said:

I think he should have been told, and had staff talk to him about it and about his treatment. I don't know whether he should or should not have gone to hospital, but I just don't know whether he got the best care that he should have, because none of us were informed.¹³¹

Ms Clarke was unaware that her father was being treated under the Hospital in the Home program.¹³² She told us that if the NSW Government 'insists on having hospital in place for the aged care facilities, then it needs to be as a hospital in place. So he needs to be able to access doctors all the time, nurses, and...all the equipment that is required that they would have access to if they were in a hospital'.¹³³

Ms Clarke did not think her father knew or had been told that he tested positive for COVID-19. Following his death, the appropriate records had not been kept by the facility and Ms Clarke struggled to obtain the death certificate necessary to hold her father's memorial service.

She said:

There needs to be more support for family members, more support for residents, and more communication.¹³⁴

Representatives from Dorothy Henderson Lodge were clear that the transfer to hospital of residents with COVID-19 in the early stages of the outbreak assisted in controlling the outbreak. Ms Melanie Dicks, Residential Operations Manager, Southern region, BaptistCare, explained that it helped the provider to ‘stabilise our outbreak plan and ensure that our resources were working’.¹³⁵ In particular, it enabled BaptistCare to ‘say that the service had no active cases at that point, and it certainly supported encouraging staff to come as well because at that time staff were fearful to come on site so we had to work strongly and support our staff to ensure their safety’.¹³⁶ The submissions from Anglicare responding to those of Counsel Assisting made similar observations based on the experience at Newmarch House, including the experience of residents and their families.¹³⁷

The independent review of Newmarch House revealed that there were ‘impediments’ to the ‘successful implementation’ of Hospital in the Home at Newmarch House, ‘the most significant of which was a shortfall in staff familiar with the regular care needs of residents’. In addition, the number of residents with COVID-19 was increasing, which was a ‘continued source of infection to other residents and staff because of imperfect’ infection prevention and control practices. The independent review also identified a ‘lack of adequate provision for medical care of the majority of residents who remained COVID-19 free’ which led to ‘shortfalls in hospital-standard care for some residents with COVID-19 and neglect of or delays in, routine care of many others’.¹³⁸

These concerns led the independent review to conclude that the ‘successful adoption of Hospital in the Home as a model-of-care, for a large number of residents with COVID-19 in an aged care facility, is very challenging’ and to identify the following ‘key learning’ in the report:

HITH [Hospital in the Home] is an attractive model of care for management of a COVID-19 outbreak in an aged care facility but the precondition of resident safety is only likely to be met if the outbreak is limited to a small number of cases in residents and staff.¹³⁹

The evidence before us, limited as it is, supports this view. However, we note that NSW Health maintains that the experience at Newmarch House ‘does not lead to the conclusion that a HITH [Hospital in the Home] model is unsuitable for a large outbreak’.¹⁴⁰ The aged care advisory body we propose should consider this issue and provide guidance to governments and the aged care sector about the future use of Hospital in the Home in COVID-19 outbreaks.

On the broader question of whether residents who test positive to COVID-19 should be transferred to hospital for treatment, the independent Newmarch House review was clear. Another ‘key learning’ it identified was that an ‘expert panel’ of suitably qualified medical practitioners should make decisions about clinical care and:

as soon as an outbreak is declared...residents should be transferred to hospital until the residential aged care facility is deemed safe and appropriate for residents to return.¹⁴¹

There is no single answer to whether residents with COVID-19 should be transferred to hospital or whether they should receive treatment at the home. There is no ‘one size fits all’ answer because facilities vary in their capacity to separate negative and positive residents and in the numbers and skills of their staff. And as we have seen, the States, which run the hospitals and act as ‘gatekeepers’, apply different policies.

What is clear is that:

- The starting point must be to recognise that equal access to the hospital system is the fundamental right of all Australians young or old and regardless of where they live.
- The decision about whether to transfer a resident with COVID-19 to hospital or to care for them through Hospital in the Home must be made considering both the wishes of the resident who has tested positive and the right of the other negative residents to remain negative.
- The decision should be informed by broader public health considerations, such as the ‘precautionary principle’ and the ‘population-focused principle’.
- Any policy on the use of Hospital in the Home in residential aged care facilities must be developed in consultation with the aged care sector and should ordinarily be confined to small outbreaks, as recommended by the independent Newmarch House review.
- If Hospital in the Home is to be implemented in an aged care facility all relevant pre-conditions must be met before implementation.

In June 2020, Aged & Community Services Australia (ACSA), a national peak body for not-for-profit, church, charitable and for-purpose providers, released a framework that addressed the interconnections between aged care and health care during COVID-19. In it, ACSA called on the Australian and State and Territory Governments ‘to develop and adopt clear protocols for the management of the interface between...residential aged care and hospitals’ during the pandemic. According to ACSA, the proposed protocols would achieve the following:

- Ensure aged care residents can access their right to acute care in hospital, or another location that is well set up to manage infection control and treatment, if they clinically require it;
- Ensure aged care residents at a facility where an outbreak occurs are not put in harm’s way by any obstacles to transferring aged care residents diagnosed with COVID-19 to the appropriate acute care setting; and
- Develop clear guidelines for the additional support measures to be provided by the health system should an outbreak require the establishment of ‘hospital in the home’ arrangements in an aged care facility.¹⁴²

We commend this proposal. In its submissions responding to the submissions of Counsel Assisting, NSW Health agreed that there should be clear protocols and stated that ‘the protocol between the Commonwealth and NSW seeks to address this need’.¹⁴³ These matters should be considered by the national aged care advisory body which we propose. There is a need, as Mr Millard said, ‘for a much closer collaboration as an entire health system’ at a State and Australian Government level.¹⁴⁴

5. Infection control expertise and personal protective equipment

Recommendation 5

All residential aged care homes should have one or more trained infection control officers as a condition of accreditation. The training requirements for these officers should be set by the aged care advisory body we propose.

Recommendation 6

The Australian Government should arrange with the States and Territories to deploy accredited infection prevention and control experts into residential aged care homes to provide training, assist with the preparation of outbreak management plans and assist with outbreaks.

5.1 Infection control

There is nothing more important to help providers prepare for and respond to COVID-19 outbreaks than access to high level infection prevention and control expertise.¹⁴⁵ Providers of aged care are required under existing Standards to minimise infection-related risks by implementing 'standard and transmission-based precautions to prevent and control infection'.¹⁴⁶ But for COVID-19, there are particular challenges associated with infection control in aged care homes as explained in a report dated 24 May 2020 about the Newmarch House outbreak by the NSW Clinical Excellence Commission:

Newmarch House not unlike many aged care facilities is a challenging environment to implement such high levels of precautions, isolation and enhanced use of PPE. This is then compounded by the lack of onsite Infection Prevention and control expertise or external oversight of Infection Control where onsite may not have been possible.¹⁴⁷

The Clinical Excellence Commission report made some important observations about infection control that we consider are of general application to the aged care sector:

RACF [residential aged care facilities] such as Newmarch would have some experience implementing transmission based precautions and outbreak management particularly for management of other respiratory borne illnesses annually such as influenza, however I suspect given the communicability of COVID-19, the high transmissibility and the unusual enhanced approach implemented, this scenario,

despite national recommendations in place is unprecedented and relies heavily on specific environmental controls that would require Infection control expertise to set up, monitor, evaluate and at times interrogate further. Successful management of this magnitude also relies on an existing culture of compliance to and emphasis on basic and ongoing infection control education and training in addition to operational accountability for Infection Prevention and Control; again something not necessarily unique to Newmarch.¹⁴⁸

Professor Gilbert made similar observations and identified similar needs in a report she was commissioned by the Australian Government to prepare about the outbreak at Dorothy Henderson Lodge. So too did Professor Gilbert and Adjunct Professor Lilly's report into the Newmarch House outbreak.¹⁴⁹

Based on the findings of these various reports, it is apparent that high-level infection control expertise is needed by aged care homes:

- to assist with the preparation and implementation of outbreak management plans
- to provide training to staff on the use of PPE and infection prevention and control
- to provide assistance on day one of an outbreak.

Ms Kathy Dempsey of the NSW Clinical Excellence Commission explained the process by which infection control and prevention specialists are accredited. Ms Dempsey said that credentialing is carried out by the Australasian College of Infection Prevention and Control. There are currently 66 credentialed infection control and prevention specialists across Australia, mainly in major hospitals.¹⁵⁰

Several witnesses agreed that access to accredited infection control and prevention specialists could assist the aged care sector.¹⁵¹ We consider that the Australian Government should make arrangements with the States for easy access by providers to these accredited specialists. This should be able to be achieved on a regional basis. It is true, as the Australian Government submitted, that 'infection control specialists are organised and engaged by the public health units of each State and Territory'.¹⁵² However, we consider that the Australian Government, as the government responsible for residential aged care facilities, should be working closely with the States to make infection control expertise available to the sector.

We accept that there are clearly limits to what the relatively small number of accredited experts can contribute through their direct involvement in the aged care sector. The best approach may be to use their expertise in training and mentoring roles to increase capacity in the aged care sector.¹⁵³ Professor Gilbert considered that:

infection control professionals within hospitals in the local districts...could probably provide advice and training to staff outside of this outbreak scenario which would probably make everybody more prepared to respond quickly when the situation arises.¹⁵⁴

We consider that the ideal model is for each aged care home to have at least one dedicated ‘infection control champion’. Anglicare Sydney has identified two staff members from each of its homes to be trained to fulfil this role. These staff members have been enrolled in a six-month course and are being mentored by Ms Dempsey.¹⁵⁵ This is a model that should be spread throughout the sector without delay.

We note that this is not a new idea. Long-term care homes in Hong Kong have been required to have designated Infection Control Officers since 2004. The requirement was introduced after the Severe Acute Respiratory Syndrome (SARS) epidemic and has greatly assisted the response to COVID-19 in 2020. Their role is to coordinate and implement infection control measures in accordance with the *Guidelines on Prevention of Communicable Diseases in Residential Care Homes for the Elderly*.¹⁵⁶

Closer to home, the Victorian State Coroner recommended in 2012 that the Victorian Department of Health, in consultation with the then Australian Department of Health and Ageing, require aged care facilities to have a designated Infection Control Manager.¹⁵⁷

5.2 Personal protective equipment

Training in the use of PPE across the aged care sector was described by a representative of a trade union with members who work as personal care workers as ‘completely inadequate’ in the context of a pandemic.¹⁵⁸ Personal care workers do not receive training on the use of PPE as part of their Certificate III.¹⁵⁹ Graduate nurses receive a working knowledge of PPE and gain an understanding of universal precautions and basic infection control principles as part of their training.¹⁶⁰ Mr Lye agreed that training in the use of PPE should be compulsory and of a much higher standard.¹⁶¹ This is a matter that requires urgent attention by the Australian Government, aged care providers and those responsible for the content of the Certificate III.

In her report about the Dorothy Henderson Lodge outbreak, Professor Gilbert recommended that aged care staff be provided with regular, perhaps annual, training in infection prevention and control and the use of personal protective equipment.¹⁶² We agree with this recommendation. Providing this training should be a core responsibility of providers.

Providers need to appreciate the risks associated with COVID-19. While the tragic events in NSW and Victoria may have assisted unaffected providers to learn about the need for infection prevention and control expertise, this need must be made absolutely plain in the national aged care COVID-19 plan. We need only to look at the experience of Newmarch House to understand why. Ms Roy, an experienced aged care nurse, explained that when she assessed Newmarch House as ‘best practice’ in relation to infection control and preparedness, she relied on the CDNA Guidelines which she explained caused her to treat COVID-19 ‘as a flu-like illness’.¹⁶³ With the benefit of hindsight, she told us that she now considers that ‘the level of expertise that someone like Ms Dempsey brought was unparalleled, because of her extensive experience in dealing with infection control’.¹⁶⁴

Professor McLaws explained that COVID-19 is different to influenza from an infection control viewpoint because there is no vaccination and a person with it can be infectious for four days after exposure while having no symptoms at all.¹⁶⁵ This has proven to be of grave significance to outbreaks in the aged care sector.

It is not enough to tell providers, as the Australian Government's First 24 Guideline does, that if they request help, they will be provided with a 'Clinical First Responder'.¹⁶⁶ Unless a 'Clinical First Responder' possesses the level of expertise that Professor Gilbert described, they will not be able to provide the high level of assistance that providers need.

Infection control is important not only for the health, safety and wellbeing of residents. It is important to those who work in aged care. We heard concerning evidence about unsafe conditions for aged care workers.¹⁶⁷ Large numbers of aged care workers have contracted COVID-19. Nurses, personal care workers, cooks and cleaners are required to work in close proximity to residents who are, or may be, COVID-19 positive. This was graphically described for us by Ms Diana Asmar, Branch Secretary of the Health Services Union, who told us that her union's members 'right now feel like they're on the bottom of the Titanic ship'.¹⁶⁸ Aged care workers perform intimate tasks which place them on risk of catching the virus.

Insufficient supplies of PPE and infection control training for the aged care workforce were the subject of evidence in the form of union surveys and accounts.¹⁶⁹ We heard of workers being told they could only use one glove rather than two, and a guideline at a residential aged care facility that only permitted two masks per shift.¹⁷⁰ This is deplorable.

6. Conclusion

The COVID-19 pandemic has been the greatest challenge Australia's aged care sector has faced. Those who have suffered the most have been the residents, their families and aged care staff. The suffering has not been confined to those homes which have experienced outbreaks. Thousands of residents in homes that have not suffered outbreaks have endured months of isolation which has had and continues to have a terrible effect on their physical, mental and emotional wellbeing.

We decided to hold this hearing to identify what lessons can be learned from the experience of the aged care sector's response to COVID-19 in the first eight months of 2020. We have identified a number of lessons and made six recommendations for the Australian Government to implement that we consider will better prepare the sector, its staff and its residents for any future outbreaks of this pernicious virus.

Longer-term reform of the aged care sector will be the subject of our Final Report in 2021.

7. Endnotes

- 1 Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, vol 1, pp 186–190; 217–227.
- 2 Transcript, Sydney Hearing 2, Annie Butler, 12 August 2020 at T8613.30–31; Transcript, Sydney Hearing 2, Diana Asmar, 12 August 2020 at T8615.15–23.
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