ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION IN RELATION TO THE IMPACT OF COVID-19 IN AGED CARE

Introduction

1. This submission is provided by the Australian Nursing and Midwifery Federation (ANMF) in response to the Royal Commission's invitation for written submissions to assist the Commissioners to understand the impact of the pandemic upon older Australians, their families and their carers in aged care facilities and receiving home care.

2. This submission will focus on the impact the pandemic has had on residential aged care, in particular on impacts on the quality and safety of care and the impact on the aged care workforce.

3. Attached to this submission are four documents as follows for the Royal Commission's reference:

    - NSW Nurses and Midwives Association Background briefing paper: Anglicare Newmarch House Coronavirus (COVID-19) outbreak 2020 (the Newmarch Report) (**ANM.0020.0002.0001**);
    - ANMF National COVID-19 in Aged Care Survey-Final Report conducted by the ANMF between 15th April and the 6th of May of 1,513 members working in aged care (the Survey) (**ANM.0020.0003.0001**).
    - ANMF COVID-19 Response Guideline #1- ANMF Priorities for Nursing Workforce Surge Strategies and Principles for Redeployment of Registered Nurses during the COVID-19 Pandemic in Australia (**ANM.0020.0004.0001**) and
    - ANMF COVID-19 Response Guideline #3- ANMF Principles for Safe and Compassionate Entry into Nursing Homes (**ANM.0020.0005.0001**)

4. The ANMF submits that there is much that can be learned from responses to the pandemic and that the impact of COVID-19 in aged care has emphasised more deeply than ever the need for appropriate staffing levels and skills mix.

Aged care and the pandemic

5. The COVID-19 outbreak has understandably been a particular threat to those in Australia's aged care sector. In 2017, more than one in seven Australians were aged 65 years and over. As with many infectious respiratory illnesses, older people (i.e. 65 years and older for

mainstream populations and 50 years and older for Aboriginal and Torres Strait Islander populations and other special needs groups) are at a greater risk of worse outcomes due to infection including greater likelihood of experiencing more serious illness, greater morbidity, and higher risk of dying. This is supported by national and international figures showing that hospitalisations, intensive care unit admissions, and deaths associated with COVID-19 are significantly higher amongst older people especially those with pre-existing medical conditions which account for a large proportion of older people – particularly those receiving care via Australia's aged care system.

6. The COVID-19 pandemic has been unlike any previously anticipated outbreaks. While past research and planning had forecasted the potential for similar infectious disease outbreaks, these had focussed upon viral influenza and other diseases such as Ebola. As a novel virus with many still unknown factors, no specific treatment, and no vaccine, COVID-19 took many countries and health and aged care systems by surprise. Information about and responses to the virus has been and continues to be fast paced. This has demanded agility, responsiveness, and pragmatic, decisive action.

7. Over 1.3 million people received some form of aged care in the year 2017-18, most receiving home-based care and support, with the remainder living in residential care.

8. For older people, even what would be a mild infection such as a cold or common influenza for a younger and/or healthier person can be serious and life-threatening. In Australia, hospitalisations and deaths due to influenza are consistently higher amongst older people despite the existence of effective vaccinations and treatments. In the case of COVID-19 however, no such vaccination nor treatments exist, so while vaccination may be an effective intervention for known viral illnesses, for COVID-19 infection prevention and control are currently our first and only line of defence. The close proximity of people in residential aged care and need for staff to provide care for multiple people often in the context of relatively low numbers and skills mix of staff also increases the risk of infection and harm.

9. For this reason, it is important that there are the right number of the right kind of skilled and well supported staff to provide safe, effective care to vulnerable residents in line with best practice infection control evidence.

10. ANMF members, through their efforts in attending work in extremely challenging circumstances, adapting to rapidly changing work requirements, including the use of PPE, implementing infection control and supporting aged care residents in periods of social isolation have been instrumental to the success in controlling the spread of the virus among vulnerable older people. We must be proud and grateful for the work of RNs, ENs and personal care workers in aged care throughout the pandemic.

11. Despite the overall success of protecting people in residential care and home aged care, which is reflective of the relatively low numbers of infection and mortality in Australia more broadly, there has been tragic loss of life experienced in the aged care sector. Of the 104 recorded

COVID-19 related deaths, 30 of those were residents of aged care[1] . Nineteen of those residents were from Newmarch House and 6 from Dorothy Henderson Lodge.

12. The ANMF submits that in looking both at the details of the response in the NSW's nursing homes and at the sector as a whole, there is much that can be learned and much that further highlights the systemic problems in aged care that have already been identified by the Royal Commission. This submission, read in conjunction with the NSWNMA report, identifies problems specific to and highlighted by the impact of the pandemic. The ANMF welcomes the opportunity to make submissions on what can be learned from the experiences of the last months and what can be done to ensure the future safe and quality delivery of care to elderly and vulnerable Australians.

Staffing levels and skills mix

13. The ANMF has long contended that staffing levels and skills mix in residential aged care has been inadequate to ensure consistent safe and quality care. The ANMF refers to its previous submissions in relation to staffing levels and skills mix. It is of great concern that 80% of respondents to the Survey reported that there had been no increase in care staff to prepare for a potential COVID-19 outbreak.

14. It is the ANMF's contention, that inadequate staffing levels and lack of adequately skilled staff in nursing homes and across the aged care sector have contributed to many of the issues of concern raised in this submission.

15. The effects of short staffing have been compounded by the pandemic. Workload has increased, but in many instances staffing levels have not. A member described the extra workload in the Survey:

' *We have had no increase in staffing levels, still suffer short staffing. I work night shift one to 40 residents. We do not have kitchen staff, laundry staff or cleaning staff, you have to do all of this plus look after residents. Now each shift is expected to clean all surfaces on top of what is previously mentioned. So no change at all, just extra work which you struggle to do*.'[2]

16. The ANMF submits nursing homes must be staffed with at least one RN at all times. This must be adjusted to ensure adequate RN staffing for the number of residents and that it is adequate in light of restrictions on movement and nursing home layout during the pandemic.
17. Chronic understaffing, that existed before the onset of COVID-19 has been further highlighted during the course of the last months. Aged care providers have identified it has been difficult to source surge workforce, needed to supplement existing staffing requirements when self-isolation or quarantine has been in place. Staffing shortages have been further exacerbated by some employers taking a blunt approach to infection control, for example by attempting to preclude staff with more than one employer from continuing to work at more than one site.

[1] Australian Government, Department of Health COVID-19 cases in aged care services- residential care
[2] National COVID-19 in Aged Care Survey- Final Report

18. The period of limited contact with residents, due to either discretionary closure of nursing homes to visitors, or meeting state and territory-based emergency management requirements, has resulted in higher levels of responsibility on staff engaged within nursing homes. The input of families, friends, volunteers and external health providers has been limited during the pandemic. Staffing levels and skills mix must be maintained to ensure the ongoing needs of residents and the delivery of safe and quality care.

Government response and lack of consultation

19. The ANMF considers that overall, the aged care sector has been unprepared/ill-prepared to meet the needs of operating within a pandemic environment. All the long standing aged care issues identified by theANMF and numerous inquiries have degraded the capacity of the sector to rapidly and comprehensively respond to the pandemic risks. This pandemic appears to have been a stressor that has further broken an already damaged system. For example in terms of pandemic preparation:

- long standing staffing and skill-mix issues have hampered developing a surge workforce and delivery of the increased clinical care that would be required for a facility outbreak
- lack of pandemic preparation, which should take place on the basis of a "when" not "if" approach has resulted in lack of protective equipment and training at the coalface, supply chain issues and inadequate "stand up" processes to effectively manage such as situation (as appears to have been the case with the Newmarch House outbreak in Sydney).

20. The ANMF submits it is in aged care that shortfalls in the response to COVID-19 have been most stark and where lessons for future management can be learned. The ANMF considers that the Government could have improved its efforts to listen to and involve health experts, unions, and staff to respond more effectively to the pandemic in the aged care sector. The ANMF wishes to note that unfortunately - aged care, particularly residential aged care - the area where people are most vulnerable to infection, illness, and death appears to have suffered from a lack of clear, consistent information regarding how best to respond to outbreaks as well as a lack of clear leadership and delegation of responsibility for ensuring the health and safety of older Australians, younger residents, and staff.

21. This may have in part arisen from the ongoing issue that residential aged care is often considered and staffed in order to provide more for residents' personal care needs rather than for their often complex and multiple health care needs. While the social and personal care needs of nursing home residents are indisputably important and must continue to be safely met as well as possible even during an outbreak of an infectious disease, it is the ongoing de-skilling of aged care of which the Commission is already clearly aware, where fewer nurses and other highly trained and regulated healthcare are employed that has meant that nursing homes are put at greater risk of being unprepared to manage a serious threat to the health and lives of residents, many of whom have existing and serious health issues.

22. The government did not consult effectively with unions and experts regarding their development of strategies for the aged care sector to manage the COVID-19 outbreak in Australian aged care facilities and services. Some government resources for aged care such as the Communicable Diseases Network Australia (CDNA) National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia Coronavirus Disease 2019 (COVID-19) Outbreaks in Residential Care Facilities also failed to provide clear, definitive information to support staff in nursing homes to respond to a COVID-19 outbreak.[3]

23. The lack of coherent Government response in the aged care sector is made apparent when comparing it to the operation of the health sector, in particular the acute health sector, which benefits from long established and well understood chains of command.

24. Lack of leadership and clear understanding about reporting lines, decision making and co-ordination of information, resources and infection control responses has been apparent, particularly as illustrated in the case of Newmarch House. The CEO of Newmarch House expressed his confusion to the media-'

    '*Right at the outset there was frustration about who we needed to take direction from*',[4]

25. The ANMF would support the development of a national aged care guideline for responding to global pandemics, epidemics or widespread infectious diseases outbreaks. Such a guideline should address:
    - Federal, State and Local Government responsibilities
    - Clear reporting and communication lines between the different tiers of Government
    - points of contact at each tier
    - consultation with stakeholders
    - Guidelines for the supply and usage of PPE
    - Ongoing support for training and infection control preparedness

Clinical Governance and oversight

26. Responding to the pandemic, particularly in the early months of COVID-19 in Australia, has required rapid action and decision making across all areas of society. Due to the vulnerable nature of people accessing aged care services, providers have been at the forefront of being required to take swift action to protect residents. The implementation of infection controls that meet the needs of residents, staff and families has been and continues to be essential to controlling the virus in aged care settings.

27. There has been a plethora of material provided by Government to assist providers in understanding and implementing infection control measures. The ANMF is concerned that this information has come from multiple sources, may in some instances have been

[3] CDNA National Guidance for the Prevention, Control and Public Health Management of COVID-19 outbreaks in Residential Care Facilities in Australia Version3.0
[4] Proof Committee Hansard, Senate Select Committee on COVID-19, Tuesday 26 May 2020, p3

inconsistent and providers may not necessarily have had the knowledge and understanding, staff and skills necessary to implement measures adequately.

28. For example, the Communicable Diseases Network Australia (CDNA) published an extensive guideline 'Corornavirus Disease (COVID-19) Outbreaks in Residential Care Facilities [5] which sets out expectations and guidance for nursing homes. To successfully implement these guidelines and infection controls, such as the correct use of PPE requires each nursing home to have staff with a high level clinical knowledge and understanding.

29. The ANMF submits that there must be a requirement for providers to have clinical governance expertise at the Board level in order to ensure both that infection control measures are understood and appropriately implemented.

30. In addition, nursing homes must be staffed to provide the appropriate skill level at all times to meet the operational delivery of infection control and to respond to any emerging concerns. One member explained the difficulty as follows:

*"…[W]e do not have a thorough contingency plan for positive cases of C-19. At our facility, we also have a new manager who does not have any clinical experience, which means that all decision making for infectious control rests solely on the shoulders of our deputy, who was only been in her role for ~12months. I am also concerned that our staff are not properly educated for C-19, our educator has only provided a leaflet in our houses for us to look at and sign when we get the chance. Education that is not compulsory or delivered face-to-face (especially around PPE best practice) increases our risk of transmission within the facility and demonstrates a lack of willingness to ensure all staff are adequately prepare*d."[6]

31. Appropriate levels of clinical governance, skill and expertise are essential both in managing infection control but also the added complexities that may arise during a pandemic.

32. Unfortunately, the level of complaints received by the Aged Care Quality and Safety Commission during the months of March, April and May,[7] indicate residents' loved ones have not been confident of the level of care delivered, or have been concerned about how measures have been implemented. The ACQSC reported in June that there had been a significant increase in complaints in the last 3 months. Key issues raised associated with the COVID-19 pandemic include:

- visitor restrictions, including where they exceed jurisdictional legal directions
- concerns about preparedness and prevention
- impact on the quality of care
- concerns about flu vaccinations

[5] CDNA National Guidance for the Prevention, Control and Public Health Management of COVID-19 outbreaks in Residential Care Facilities in Australia Version 3.0
[6] ANMF National COVID-19 in Aged Care Survey- Final Report
[7] https://www.agedcarequality.gov.au/news/newsletter/aged-care-quality-bulletin-19-june-4-2020

- concerns about social isolation
- concerns about possible confirmed cases of COVID-19
- impact on staff numbers and safety.

33. The ANMF considers there must be close scrutiny of complaints made during the months of lock down to ensure that the issues have been addressed and that they inform future guidance and regulation in response to pandemics or infectious disease outbreaks.

34. It is too early to tell what may have been missed in terms of care during the period of lockdown. The ANMF is concerned there may have been an increase in the incidents of pressure injuries and symptoms of dementia have escalated disproportionally during the period of lock down and visitor restrictions. These issues must be examined and the three mandatory quality indicators provided by aged care providers to the Department of Health for this period require transparent analysis. Any reduction in quality of care must be addressed through appropriate staffing levels and skills mix and appropriate clinical governance and leadership.

35. The ANMF submits there must be ongoing work to ensure robust clinical governance measures in place at all nursing homes at all management levels. This must be supported, promoted and monitored by the appropriate regulatory authorities. Future pandemics or outbreaks of infectious disease will be better and more swiftly managed if clear guidelines and protocols are in place and there is the necessary skill level available and in place when required. There must be clear leadership structures in place with clear lines of responsibility for both day to day decision making and overall management strategy.

WORKFORCE IMPLICATIONS

36. Nurses and care workers are integral to the effective operation of the Australian aged care systems. During infectious disease outbreaks such as COVID-19, they are at the front line of response efforts and are integral to identifying, managing, and treating patients with confirmed or suspected COVID-19 infection as well as dealing with ongoing and everyday aged care activities.
37. Members commented in the survey to the effect that they understand the vital role they play, but that this has not been appreciated:

"I care a lot about my residents. It pains me knowing there is not enough staff to efficiently care for them, so I step up when need be."

"…We have provided safety, security, love, and extreme resourcefulness and quality of life in the most difficult of circumstances that we as an industry have ever had to face and we are tired of being seen as substandard and all rogues because we are most certainly not…"

38. As a workforce, nurses and care workers have, as with other frontline workers, faced balancing providing care to residents and looking after their own health and safety and that of their families and loved ones. While some measures have been put in place to support

aged care workers, there is little that can be seen to have provided sufficient support and recognition for their work.

The Retention bonus

39. On the 20 March 2020 the Commonwealth Government through the Department of Health, announced a $445m aged care package to support aged care providers, residents, staff, and families. $234.9 million of this package is directed at providing a COVID-19 retention bonus to ensure continuity of the workforce for aged care workers in both residential and in-home care.[8] The retention bonus is to be paid to employers for two quarters, being the March and June quarters in the following quarter and is expected to be paid on to eligible staff. Full-time direct care workers in residential care will receive $800 and in- home care $600. Part-time workers will be paid a pro-rata payment for the amount of time they work.

40. The ANMF acknowledges that the purpose of the retention bonus is to assist in maintaining continuity of employment in the aged care sector. It recognises the increased workload pressure to meet the requirements of infection control and to manage any outbreak. Aged care workers earn on average less than their counterparts in the public sector. It is appropriate to provide an incentive for aged care workers to remain in the sector which already suffers from relatively poor worker retention when the need for skilled and experienced workers in the sector is higher than ever. In order to ensure quality of care, a stable workforce that is familiar with the care needs and preferences of individual residents is of particular importance, especially where the support and assistance of family members and friends is limited due to necessary but nonetheless distressing visiting restrictions that aim to protect vulnerable residents from infection.

41. The Federal Government did not release details of how the retention bonus would be paid until 4 June 2020[9]. In the intervening months many ANMF members raised questions about whether they would be eligible for the payment and how and when it would be paid. This period of uncertainty has been unfortunate and should be avoided in future. The ANMF is concerned that there remains inadequate awareness of the retention bonus among both staff and providers which may result in some eligible staff not being aware of their entitlements. In addition, there must be adequate auditing measures in place to ensure providers have passed on the correct amount to all eligible employees as the intended retention bonus.

42. The ANMF also expresses its extreme disappointment at the shortcomings of the retention bonus. It was initially advised that it would be a gross payment and not subject to tax. It was also understood to be payable to all casuals working in aged care, regardless of the length of service and was anticipated to have been paid in June. Aged care workers have waited for the payment, for details of the payment and anticipated the full amount of the retention bonus to be paid to them. The delay, lack of detail and reduction in quantum are indicative of the poor regard in which aged care workers are held.

[8] https://www.health.gov.au/resources/publications/aged-care-workforce-retention-bonus-frequently-asked-questions-for-residential-and-in-home-aged-care-workers

[9] ibid

43. Further, the ANMF considers the retention bonus payments for in-home care workers should be increased to match that of residential care workers and be extended to all staff working in residential care.

44. As providers and aged care employment agencies will receive the retention bonus on behalf of employees it is also necessary to ensure there are appropriate reporting and auditing measures in place to ensure the retention bonus is received by all eligible employees.

45. The ANMF considers it may be appropriate to extend the period of time over which the retention bonus is payable, noting attraction and retention of staff in aged care may be affected by the pandemic for many months or even into next year. Any extension of time is subject to the above concerns being addressed.

Pandemic Leave

46. On its own initiative, the Fair Work Commission (FWC) proposed to amend the majority of Modern Awards, including the Nurses Award and the Aged Care Award, to make provision for employees to be able to access up to two weeks unpaid pandemic leave. The ANMF welcomed this initiative and the subsequent variation of the awards. The ANMF, along with other health sector unions and the ACTU, argue that to be truly effective in limiting the spread of COVID-19, pandemic leave- whether for the purposes of self-isolation, being tested, or infection with the virus, must be paid.

47. The ANMF in conjunction with the ACTU and other health sector unions has made an application at the FWC to vary awards that cover workers in the health and community sector. The ANMF is an applicant with respect to the Nurses Award and Aged Care Award. The application asks that awards be varied to provide for paid pandemic leave, where an employee is required to self-isolate, be tested for COVID-19 and await results, or is infected with the virus.

48. As is evident in countries throughout the world, front-line health care workers, of whom nurses make up a large proportion of the workforce, are contracting the COVID-19 virus due to high levels of exposure. There is evidence to indicate that health care workers are being infected at higher rates than the general public[10] – even acknowledging that testing rates are also higher. In addition, there is evidence that health care workers are experiencing more serious symptoms as a result of contracting COVID-19 than the general public. This may be due to exposure to greater viral loads due to providing direct care to patients with COVID-19.

49. Aged care is an essential service, that must continue to operate and the protection of residents who are highly vulnerable to the impact of COVID-19 must be paramount. Staff who

10 https://anmf.sharepoint.com/sites/COVID19novelcoronavirus/Evidencebriefs/Forms/AllItems.aspx?id=%2Fsites%2FCOVID19novelcoronavirus%2FEvidencebriefs%2FANMF%20Evidence%20Brief%20COVID%2D19%20%2D%20Protecting%20healthcare%20workers%20from%20infection%2Epdf&parent=%2Fsites%2FCOVID19novelcoronavirus%2FEvidencebriefs

care for these vulnerable people who have been exposed to COVID-19 are and will continue to be required to self-isolate to minimise the risk of infection in vulnerable groups of people.

50. It is highly likely that aged care workers may be required to self-isolate on more than one occasion to minimise the spread of infection due to potential exposure to the virus as well as due to experiencing unrelated respiratory symptoms and being required to self-isolate until test results are confirmed.

51. As noted above, testing aged care workers is a crucial measure to identify risks of outbreak and control any outbreak as early as possible. Workers waiting for test results must be paid while they wait for test results and supported to stay at home during this time. Failure to provide paid pandemic leave is likely to adversely impact upon workforce supply, retention, and in the long run, attraction. All issues known to be especially pronounced in Australia's aged care sector.

52. The provision of paid leave for staff in aged care to be able to self-isolate, quarantine, be tested or if experiencing infection, would be a significant support for staff and minimise the risk of spread of infection amongst vulnerable residents and aged care recipients. Provision of paid pandemic leave is currently sought in direct response to COVID-19, but would be equally applicable for any other epidemic or outbreak of infectious disease.

Personal Protective Equipment

53. Provision of PPE in the workplace is essential for the protection of both staff and residents. ANMF members report, however, that supply of PPE has been inconsistent (i.e. insufficient supply, inadequate access, incorrect type and range) and guidelines for its use have also been variable.

54. Through the ANMF survey members told us:

"Management has PPE, but its rationed very strictly, and not appropriately and Infection control is not appropriate as we are told to remove the PPE from the hallway and put it in the residents room, but this is not adhering to infection control at all."

"Nil access to PPE, no extra staff to help with cleaning, even in lock down, residents are still going out into the community."

"Our facility began planning early. However, we were low on PPE at the beginning of the outbreak and it was difficult / expensive to restock."

"We have consumers coming from hospital. The management put them in 15 days COVID-19 isolation, but they don't provide any PPE while attending them. This is really disappointing and stressful to me."

"As per federal guidelines, even if there's a confirmed outbreak, we aren't required to wear PPE unless dealing with that specific resident. This ignores the fact it's highly contagious and spreads asymptomatically."

"The plan provided by my employer is detailed and comprehensive, but I doubt that with the current staffing ratios and PPE we have that it is possible to adhere to."

"We have very little supply of PPE and hand sanitiser, what little stock we do have has been locked up by management and RNs were instructed to ask the DON if any stock was required before we can take/ use it. Staff were washing their hands with shampoo as there was no hand soap available."

"We have a limited amount of glove and gowns, so if we did have an outbreak of anything we would run out within a day or two."

"All PPE is locked in managers office. Staff have been instructed to use only one glove. We are not allowed to wear a mask at work. We only have plastic sleeveless aprons. Manager says carers have to bring an empty box of gloves to have one replaced and are being questioned making them too afraid to ask. Staff have been buying their own and using plastic bags on their hands. Last week I asked about the residents who were quarantined and was told I (and care staff) were not allowed to wear PPE despite department guidelines saying so. Staff told not to come to work unwell but one nurse was told to come after her husband had a fever and sore throat and maintenance man had a fever on a weekend and was told to come to work Monday morning. No contactless thermometers and staff taking residents temps daily reusing disposable thermometer probe covers."

55. The ANMF remains concerned that supplies of PPE, both at the stockpile level and local supplies may not be adequate to meet future demand. In addition, and in part because of a lack of evidence, which will become available in the coming months and years, there has been inconsistent information about the type of PPE to used in various settings. The ANMF considers in future, comprehensive evidence based guidelines about the use of PPE must be developed.
56. Further, consistent training in the use of PPE must be provided across the sector to reduce uncertainty and minimise risk. The supply of PPE to aged care providers must also be safeguarded.
57. Providers must be mandated to supply the appropriate PPE to staff in accordance with best practice guidelines. As the above comments from members show, some providers have withheld supplies of PPE due to concern about cost and the adequacy of supply. This is both short sighted and potentially highly risky conduct that could endanger the lives of both residents and staff.

Additional on-line training opportunities

58. While standard infection control measures are in place and are expressed in policies and procedure documents, the pandemic has required staff to be highly conversant with often complex and changing infection control measures. This has necessitated additional training requirements, particularly in relation to the correct choice and use of PPE. Much of this has been accessed online.

59. However, many members have advised that the training provided has not had sufficient practical demonstration or has been 'tick-a-box' in nature. Members reported feeling unprepared in practice or unsupported in their workplaces to implement what they had learned:

"Have an Education RN but all done is leave papers in staff room to read and sign. Online education at work provided. Actual education re practice donning of PPE not done. It is all tick the boxes by collecting signatures really."

"Online training on infection control which is the same basic vague information that is used for mandatory training."

"We were required to complete one online respiratory infection unit training that included a hand washing and PPE instructions. We have not had hands on training of don and doffing PPE."

"We have received online training, but I have not seen the correct PPE in stock or available to us if an outbreak was to occur."

"We have had training on correct use of PPE... we just don't have the PPE!!"

"Education modules are provided as online learning. I'm not sure if there was a specific infection control module, however we have an annual hand washing audit for all staff. This year's audit was very disappointing, as the educator did not demonstrate how to wash your hands, did not check each individual and did not use the correct tools to show the before/ after hand washing. Rather, she stood at the front and said: "wash your hands like this and do it with me" and then signed everybody off. As there were a lot of new staff starting at this time, it's concerning that many newcomers to aged care may not have properly learnt this important skill. Infection control was also included in the leaflet re. C-19 which was left in the offices at work for people to read and sign."

"Don't even do appraisals or performance management. Only have a small infection component in mandatory online training we do in our own time."

60. In future, training requirements and delivery should be kept up to date and include practical hands on training components in order to ensure all staff in aged care are confident in the correct infection control measures to utilised in response to infectious disease outbreaks.

Opportunities to return to the workforce

61. The Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards including the Nursing and Midwifery Board of Australia (NMBA) has put in place a number of measures to allow student, graduate, and retired health practitioners including nurses to return to the workforce. An opt-out sub-register was created for experienced and qualified nurses as well as other eligible practitioners to help with fast-tracking their return to the workforce and to assist if required to meet additional workforce demand. As of the 10th of June, 21,887 nurses were on the sub-register.

62. In the ANMF survey of aged care staff 53% indicated their willingness to increase their shifts or hours to assist with the additional workload arising from managing the pandemic. Notably, this also included staff who already worked fulltime.

63. The ANMF notes this indicates the willingness of RNs, ENs, and aged care workers to participate in the workforce and to offer their skills and experience to assist the Australian community during the pandemic.

64. The ANMF submits that the first source of surge workforce to respond to any outbreak of COVID-19 in aged care should be from the existing skilled and experienced workforce.

Further support measures

65. ANMF members have told us that at times they have not felt supported in their employment or in coping with demands of working during the period of lockdown. Members have described feeling isolated both professionally and emotionally. For example, RNs rostered to work shifts without sufficient clinical support have felt confronted by making difficult decisions alone and without the benefit of peer or managerial support.

"In several occasions, shortage of nurses is becoming a norm. Management doesn't try harder to cover vacant shifts."

"Told if they call in sick won't be replaced."

"Nights we are allocated one RN to four separate buildings of upwards 170 residents. But we do not always have one turn up and they don't replace the shift, so we work with two ENs and 10 AINs for night shifts."

"It used to be two RNs in the morning shift, but since they have temporarily stood down staff working two nursing homes, some days it has been consistently not replaced. One RN is expected to work the same workload if the two RN and they replace the RN shift with an AIN to assist one RN on the floor. We were told that if you are not able to manage, which means they cannot roster or give you the shift."

"Insufficient numbers of Registered Nurses… That is why they reduced their hours or left! Sick of the bullying and harassment and demands to work unpaid hours."

"We have trouble retaining nursing staff. Had a big turnover as the nurses come to facility but worried about their registration being compromised due to management of facility not being medically qualified to advise them on how to do their job. We only opened a couple of years ago and only have a couple of our original nurses still there. Much agency nurses used."

66. Others have found balancing work demands, increased workload and family commitments difficult. For some staff who reported that they would not be willing to take on additional hours or shifts during COVID-19, family commitments such as needing to home-school and/or look after children or take care of older family members were cited as reasons.

67. The ANMF asks that aged care workers be supported through their employment. This might include access to Employee Assistance Programs and acknowledgement that this has been a period of great uncertainty and emotional strain. There will be an ongoing need to provide emotional support to aged care workers who have provided support to residents, families, experienced community back lash and anxiety about their own families and the risk of transmission.

Increased funding for aged care

68. As of the 26 June 2020, around $850.8 million for aged care has been promised by the Commonwealth Government in support of responses to COVID-19. In addition to funding of $234.9m for the retention bonus, funding initiatives have included:

    - 78.3m in additional funding for residential care to support continuity of workforce supply.

- $26.9m for a temporary 30 percent increase to the Residential and Home Care Viability Supplements and the Homeless Supplement. This includes equivalent viability funding increases for National Aboriginal and Torres Strait Islander Flexible Aged Care Program providers, Multi-Purpose Services and homeless providers.
- $92.2m in additional support to home care providers and organisations which deliver the Commonwealth Home Support Programme, operating services including meals on wheels. This will include services for people in self-isolation such as shopping and meal delivery.
- $12.3m to support the My Aged Care service to meet the surge in aged care specific COVID-19 enquiries, allowing for additional staff to minimise call wait times.
- $205m additional funding in recognition of COVID-19 comprising payments of $900 a bed in metropolitan areas and $1350 per bed in regional areas
- $101m to support upskilling care workers in infection control, boosting staff numbers, support and training for residential staff and a range of other measures
- $52.9m for grants to reimburse approved aged care providers for eligible expenditure managing direct impacts of COVID-19 in the period from 24 February to 31 May 2021
- $70.2 m in short term support for CHSP additional support to provide care
- $22m additional in Home Care Packages to assist workforce supply pressure as a result of COVID-19.

69. The ANMF contends that while this investment is much needed, particularly due to the known and pre-existing systemic issues regarding safety and quality in aged care, making this funding available to aged care providers without defining and regulating how or what the funds are used for runs the very real risk of this added funding not being used appropriately or effectively to protect vulnerable residents, staff, or residents' families and loved ones from potential infection. The ANMF is concerned that there is no clear requirement for providers to use this funding on activities that would help protect and provide care to vulnerable older people such as through the employment of skilled staff.

70. Specific analysis of how funds have been spent, the benefits generated and transparent accounting and reporting of each funding stream must be required of provider recipients. Future programs should be assessed based on evidence-based analysis of what has proved effective in protecting vulnerable older people and staff working in aged care.

71. The ANMF has long believed that the current aged care funding arrangements are no longer fit for purpose, do not reflect the actual costs of care using an efficient price/cost approach, and particularly, lack transparency and accountability on the part of aged care providers for funding expenditure. Given the increasing concerns regarding some provider financial viability, particularly as this now seems to be used to justify staffing changes, greater transparency of information around provider financial position is essential so that situations of genuine need can be differentiated from opportunistic behaviour during this critical time.

Workload

72. ANMF members have told us of diverging experiences in relation to their work during the pandemic. Despite the additional funding to the sector to support the workforce, members have described having considerably increased workloads :

"This is already exhausting with all the extra emotional support needed for residents, Phone calls from families and extra work monitoring and recording temps each day."

"I work night shift and the staff numbers are too low for the care needs of the residents, extra audits, and showers that are expected of us to do. Our workload is often becoming unachievable in our time span and with doing showers at 0600 hrs to 0700 hrs, by one staff it is becoming dangerous."

"I work by myself with forty residents on a night shift. Not only do I care for my residents, I am expected to do their laundry, clean my area, cook for the residents and many other tasks."

"I am currently full-time 76 hrs a fortnight, during this pandemic I have been working a min 12 hours extra a week with no pay or acknowledgement, Last week I needed to have a day off work to take my son to a specialist appt and they didn't even give me the day off as time in Lieu I had to have it off as leave without pay…"

"[Company name] are PROFIT based first and foremost... Staff are a disposable commodity... Minimum staff to resident ratios plus workload and resident demands ensures staff burn out and extremely high staff turnover... Slave labour with low pay rates = a totally dissatisfied workplace with high stress and unrealistic expectations...To put it plainly... CRUEL - Corporate GREED wins..."

"Just the lack of staffing. During these hard times we should be provided with more support, yet it seems to be the opposite and is extremely stressful and hard on staff members."

"We are run off our feet - expectations and requirements have increased significantly but no extra staffing or support for lifestyle. Expect us to link residents with families but no additional IT support or resources - having to use my own phone."

"In regards to staffing numbers - not enough! And certainly not enough to deal with an outbreak. There needs to be defined ratios. For nursing students, facilities should be taking these students under their wings and utilising them to assist the overworked EENs in a AIN capacity. Nurture those who could end up as valuable nursing staff for your facilities!"

"Very poor skills mix on floors. Lack of experienced staff; recent trainees are being placed with last group of trainees which have not been signed off (have not been post course 6 - 12 months) to "buddy". THIS HAS BEEN AN ONGOING ISSUE FOR AN EXTENDED PERIOD OF TIME. This is very demanding on the limited experienced staff on the floor to supervise the inexperienced care staff. Poor rostering, having staggered shifts, multiple staff rostered off

during times off high care needs often leaving the floors short-staffed and at dangerous levels both for staff and resident safety. It has been mentioned to management on numerous occasions that the rostering is NOT WORKING but as usual NOTHING CHANGES. Management constantly saying inadequate funds to boost care staffing levels, however the company seems to be very top heavy with management/ admin staff."

Secondary employment

73. Disturbingly, however, others have described having lost shifts or being stood down from their usual employment under the guise of minimising infection risk. For example, the ANMF is aware of some providers instigating a 'no secondary employment' policy to prohibit staff from working in more than one facility.

74. The ANMF is aware that some providers have imposed blanket restrictions on employees having more than one job. Many aged care workers are engaged on a part-time basis and rely on having more than one employer in order to earn a sufficient wage.

75. The ANMF raised this issue with Senator Richard Colbeck on 22 April 2020 outlining its concerns with the employers directing individuals to work for only a single employer noting 'the ANMF does not support this approach as we believe such a direction is generally an unreasonable and potentially unlawful direction except in specific circumstances underpinned by a sound and legitimate public health rationale.'

76. Some members have reported reductions in working hours imposed by providers under the auspices of managing infection control. This has resulted in loss of income and caused great anxiety. This may have been especially pronounced among members whose partners had lost work due to COVID-19.

77. The 'one employer only' approach taken by some employers reflected a number of industry shorthcomings:
    - An absence of a coherent industry approach to such an issue;
    - A failure to recognise that the employer's own employment policies and practices necessitate multiple employment;
    - A failure to consider the impact on other providers of such an approach;
    - A failure to address the impact on affected staff incomes; and
    - A preparedness to ignore employee industrial and employment rights

Surge workforce proposals

Short-term labour supply

78. In the course of the pandemic, there has been genuine need for surge workforce to supplement existing staffing arrangements in residential care. This has occurred when high numbers of staff have been required to self-isolate or there has been a significant outbreak of COVID-19 in a nursing home, for example as at Newmarch House.

79. While Government support to assist providers in accessing qualified staff to fill vacancies that cannot otherwise be filled for short-term COVID-19 related reasons is welcome, the ANMF is concerned about the approach adopted by Government.

80. In April 2020 the Government implemented a scheme to provide additional staffing in aged care through the on-line labour hire firm 'Mable'. The online platform was selected without the usual tender process on the basis of the emergency management provisions. The scheme offers providers with staff to fill short-term vacancies or shortages of staff caused by the pandemic- for example staff requiring self-isolation leave via an online platform. The Government scheme funds replacement staff hired through the platform for a period of 4 weeks. The scheme also promotes the platform for other vacancies that do not meet the funding criteria. The Government has allocated 5.77 million to fund this private labour hire platform. In addition, Aspen Medical has been funded up to 15.7 million to provide additional staff in the event of a significant outbreak.

81. The ANMF is concerned about the use of on-line labour hire schemes for a number of reasons. In the case of both Mable and Aspen Medical, no alternative labour hire providers are funded or offered to providers. If a provider needs to access additional staffing and receive funding, they are offered no choice of labour hire online service. This may limit availability and create inequity as to access to the 4 weeks funded assistance.

82. The Royal Commission has heard extensive evidence about the risks of insecure work in aged care in relation to quality of care and the difficulties in recruiting and retaining suitably qualified and experienced staff in aged care. The ANMF is extremely concerned that the promotion of short-term labour hire staffing in aged care exacerbates those risks and problems.

83. Staff engaged through Mable are treated as independent contractors, which may be a legally dubious characterisation of their employment and can be engaged by providers on a short-term basis. It is up to workers who register with Mable to provide details of their qualifications and appropriate checks, such as proof of registration. While Mable advises checks will be conducted, this does create risk of unsuitable workers being engaged in aged care due to a lack of oversight.

84. The ANMF is also concerned that the Government has moved to promote this form of insecure work as an alternative to providers engaging ongoing staff directly. Staff who are familiar with the needs of residents, especially during the period of limited access to nursing homes by families and friends, are essential to providing quality and safe care. As the Commission has heard on multiple occasions; residents and families value staff who are familiar with their loved ones' needs and preferences for care and the evidence for the effectiveness and appropriateness of continuity of care is irrefutable.

85. The use of a fragmented workforce in aged care must be seen as a last resort and should not be treated as an ongoing solution to recruitment and provision of aged care services.

Use of unregulated workforce

86. Counsel Assisting to the Royal Commission has recommended that a Certificate III be the entry level for working in aged care and that currently unregulated workers become subject to a registration scheme.[11] Despite this recommendation, providers have proposed to utilise unskilled and minimally trained workers (10 hours) in their pandemic response efforts as 'aged care assistants'.[12] Moves to introduce unqualified unregistered workers at low rates of pay in order to meet workforce demand must not be supported. As highlighted by the evidence before the Royal Commission, there are risks to residents if the quality of care standards are not met by a suitably qualified and experienced workforce. There is also a risk that already low rates of pay will be further undercut by utilising the proposed aged care assistant role which may further damage the sector's ability to attract and retain staff.

87. To date, there is no evidence to justify the need for this new role in aged care even during the COVID-19 pandemic as several steps have been taken to boost the existing nursing workforce. For example, the NMBA has opened a COVID-19 register of nurses who are willing to return to the workforce to meet demand. This is to be commended as an appropriate way of accessing suitably qualified and experienced nurses during times of potential patient surges and increased demand for staff and skills. Further, student nurses have and are willing to fill workforce shortages, and nurses who had hours reduced due to cancellations of elective surgery could also have been engaged end employed in the aged care sector to meet demands for care brought about by the COVID-19 pandemic, staff absences due to ill health, and the need for staff qualified and trained in infection control measures.

88. The ANMF considers it is essential to draw on the existing trained, experienced workforce in order to ensure quality and safe care for residents of aged care and recipients of aged care services in their homes as opposed to creating a less trained, unregulated role with skills and experience below that of the current unregulated workforce of carers.

89. The Government has initiated a consultation process to examine the possible methods of regulation of the currently unregulated aged care workforce. The ANMF considers it is appropriate for this work to continue and a scheme that ensures the direct care workforce is appropriately qualified and suitably skilled for work in aged care. In addition to ensuring 'fit and proper' people enter work in aged care, it is also necessary to ensure there are robust systems in place to detect and respond to any misconduct or failure to meet standards. The consultation as it addresses both these aspects should continue.

90. The ANMF has provided submissions to the Royal Commission in relation to the need for registration of unregistered personal care workers. [13] The ANMF maintains its position in relation to the importance of this part of the workforce being suitably qualified and subject

[11] Counsel Assisting's Submission on Workforce (RCD.0012.0061.0001)
[12] Altura DG, Leading Age Services Australia. Aged Care Assistant Employment Program: A redeployment workforce initiative to support Aged Care 2020.
https://dashcs.com.ay/agedcare
[13] ANM. 0006,0001.0010-13; ANM.0013.0001.0018-19; ANM.0015.0001.0029-31 and ANM.0018.0001.0016

to a registration scheme that ensures ongoing fitness and suitability for entry and remaining in the aged care workforce.

Staffing cuts

91. The ANMF is aware that some providers have advised that they will or have reduced staffing numbers due to drops or forecast drops in occupancy rates. The ANMF considers that reducing staffing levels and skills mix at this time is wholly inappropriate. Any reduction in occupancy rates is likely to be temporary. Any delay in entering residential care due to the pandemic will not be indefinite and in fact demand is likely to increase as those who have deferred entry seek to take aged care places.

Reductions in staffing numbers is contrary to all of the evidence before the Royal Commission which shows that both staffing levels and skills mix in residential care are often below the standard necessary to ensure safe and quality care.

92. Further cuts to staffing, for whatever reason, during the pandemic are unjustifiable and will simply reduce standards of care, decrease the capacity of the sector to maintain a surge workforce if needed and add to the economic hardship of those already poorly paid aged care workers who are impacted by these decisions.

93. Drops in occupancy rates may also be reflective of a lack of public confidence in aged care providers being able to provide safe and quality care during this period of heightened risk to the health and wellbeing of aged care residents. This can only begin to begin to be addressed by ensuring adequate staffing levels and skills mix.

94. The ANMF is concerned that if staffing numbers and skills mix are reduced as a response to short term concerns about drops in occupancy rates it will be difficult to attract these workers back into aged care and have an immediate and unacceptable impact on quality and safety of care.

Visitor restrictions

95. On the 4th of March 2020 the ANMF warned that urgent,[14] co-ordinated action is needed to increase the numbers of qualified nurses and carers working in the already, understaffed aged care sector where even before the pandemic, staff were known to be struggling with the provision of even basic care for residents due to widespread under-staffing and low numbers of registered nurses, nurse practitioners, and other allied and medical staff.[15] At this early stage, prior to any reported aged care outbreaks in Australia, the ANMF warned that as the aged care sector is already dangerously understaffed, a potential outbreak and consequent

[14] ANMF. ANMF calls on Government to protect nursing home residents and staff. 2020. http://anmf.org.ay/media-releases/entry/media_200318

[15] Royal Commission into Aged Care Safety and Quality. Interim Report: Neglect. 2019

lockdowns in nursing homes could inevitably result in a depleted workforce, with reduced numbers of qualified staff on the ground caring for vulnerable residents.[16]

96. At this time, the ANMF also warned of the potential problems of insufficient PPE supply and training in a sector that was largely unprepared in terms of staffing numbers and skills mixes to handle an outbreak of a highly contagious respiratory disease.[17]

97. On the 18th of March 2020 the ANMF called for a temporary ban on all non-essential visits to nursing homes, in a concerted, community-led effort to help shield vulnerable older Australians and residents from the COVID-19 global pandemic in the absence of other adequate responses.[18] The ANMF's call urged the Government to provide clear and consistent messages to avoid confusion amongst already worried residents and their loved ones. The ANMF's recommendation was made with the understanding that balancing access under compassionate grounds, particularly to ensure residents and loved ones can safely and appropriately be together where palliative or end of life care is required, with effective infection control measures is challenging. For this reason, the ANMF advocated for exemptions to visiting restrictions on certain grounds and advised that health checks and proper supports for safe visiting must be clearly communicated and implemented.[19] The ANMF's principles for visitor access to residential aged care facilities has also been published and details the ANMF's positions regarding safe, compassionate entry into nursing homes.[45] The ANMF also provided this document in our submissions to the consultation on the Industry Code for Visiting Residential Aged Care Homes During COVID-19.[20] (The development of the visitor code provides an example of how the Federal Government failed to adequately consult unions and health experts, consequently the document fails to address staffing requirements for residential aged care in the context of the COVID-19 pandemic.)

Interface between health and aged care

98. The experience at Newmarch House illustrates in stark terms the need for a co-ordinated and integrated response to outbreaks of COVID-19 in residential care. There are a number of enquiries underway to examine what occurred at Newmarch House and what can be learned from that experience. One area that must be examined is the decision not to take seriously ill residents to hospital.

99. Hospitals are generally better equipped to deal with infection control and to care for seriously ill patients. Residents or their family and loved ones must be given the opportunity to choose the best health care for their particular health circumstances.

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[16] ANMF. ANMF calls on Government to protect nursing home residents and staff. 2020. http://anmf.org.ay/media-releases/entry/media_200318

[17] ibid

[18] ANMF. ANMF calls for immediate stop on all non-essential visits to nursing homes.2020 http://anmf.org.au/media-releases/entry/media_200501

[19] ibid

[20] COTA. Industry Code for Visiting Residential Aged Care Homes During COVID-19. 24 May 2020 https://www.health.gov.au/resources/publications/industry-code-for-visiting-residential-aged-care-homes-during-covid-19

100. Conversely, if a resident remains in residential care during a period of illness, there must be measures in place to ensure the care provided is appropriate. This must encompass the ability to offer complex healthcare interventions, palliative care where necessary and stringent infection control to protect both staff and other residents.

101. The ANMF notes that during the COVID-19 pandemic some health and aged care providers improved their arrangements and activities regarding interfaces between the two sectors. Such collaborative actions are critical for the aged care sector to effectively manage the COVID-19 outbreak and this must continue both within and beyond the context of responding to the COVID-19 pandemic. The need for strong and consistent interfaces between aged care and healthcare has long preceded the pandemic and ongoing interface must continue to ensure the safety and quality of care provided to residents. The pandemic has highlighted that the aged care sector must be more integrated with the overall health system.

Conclusion

102. Australia's ongoing Royal Commission into Aged Care Quality and Safety has necessarily slowed due to the pandemic, but the interim findings published in the report titled 'Neglect' and in Counsel Assisting's submissions highlight that many aged care providers were not able to provide safe, quality care to residents even prior to COVID-19 due to systemic issues such as widespread underemployment and rostering of qualified workers such as registered nurses, lack of sufficient numbers of direct care staff, and deficiencies in the provision of health care.

103. The COVID-19 outbreak in Australia has stretched an already strained sector further and highlights the urgent need to respond now to issues already identified in aged care prior to the outbreak. The importance of having mandated, safe staffing levels and skills mix to provide care for residents and clients is clear and has never been higher. If providers had been staffed appropriately in terms of numbers and skills mix prior to the pandemic, the ANMF contends that coping with increased demands due to the outbreak in Australia would have been significantly easier.

104. The need for lasting aged care reform remains as urgent as ever and must not be deferred as a result of the pandemic. The ANMF considers it is essential to draw on the existing trained, experienced workforce in order to ensure quality and safe care for residents of aged care and recipients of aged care services in their homes as opposed to creating a less trained, unregulated role with skills and experience below that of the current unregulated workforce of carers.

105. The COVID-19 pandemic has highlighted a number of shortcomings in the residential aged care system to which the ANMF has directed the Royal Commission's attention in earlier submissions. The degree to which the residential aged care system has to a significant extent so far avoided the terrible outcomes seen internationally is as result of good management of the crisis across the community as a whole, the dedication of staff and good luck. It simply

cannot be said that providers were equipped to deal with the crisis. The shortcomings exposed included:

- Inadequate staffing levels and skills mix and unsustainable workloads;
- An absence of clinical leadership, expertise and training;
- Failures in contingency planning, preparation and resourcing;
- An absence of coherent, consistent guidance and leadership directed to facilities and staff;
- A lack of funding transparency;
- The absence of an industrial entitlement to paid pandemic/epidemic leave and
- The comparative shortcomings of the sector when compared to the acute sector.

106. The underlying systemic failures in aged care must be reformed in a lasting, robust and evidence based manner that ensures the system has ongoing capacity to respond to health crises such as the COVID-19 pandemic. Central to that reform is the provision of staffing levels and skills mix that ensure safe and quality care at all times.