Royal Commission into Aged Care Quality and Safety

PRECIS OF EVIDENCE - PROFESSOR JOSEPH ELIAS IBRAHIM

5 August 2020

1. This precis of evidence is informed by the work of myself and colleagues commenced in March 2020 to help provide field intelligence to assist the aged care sector in the response to COVID-19. The comments do not necessarily reflect the views of any of the professionals who contributed to this process or any affiliated institutions.

2. My qualifications and experience are set out in my previous witness statement to the Royal Commission dated 23 April 2019. I have outlined some specific aspects that are most pertinent to my evidence on this occasion:

    a. **Geriatric Medicine**: specialist medical practitioner in geriatric medicine and I have been in continuous clinical practice for over 30 years in Victoria, Australia

    b. **Public Health:** Specialist qualifications in public health medicine

        i. Doctor of Philosophy in Epidemiology, Public Health and Health Services Research

        ii. Fellow of the Australian Faculty of Public Health Medicine

    c. **Knowledge of organisational and systems failures**: 20 years of academic experience researching and teaching principles and practices

        i. Developing performance measures to proactively identify potential risk of systemic failure for RACS with La Trobe University for Department of Health and Human Services[1] and developing models of aged care homes[2]

        ii. Conceived, designed and delivered postgraduate education units related to public health, aged care, safety and quality, human factors contribution to success and failures in health service and emergency responses to disasters from climate change. Evidenced in the following Masters in Public Health and Masters of Health Service Management Units including MPH5312 – Advances in managing patient care processes (2016) MPH 5311 Safety and quality in health care (2015), MPH 5042 Climate Change and Public Health (2012) MPH 5285 Human Factors in Health Care (2009), MPH 5286 Applied Patient Safety and Quality Improvement in Health Care (2009), MPH 2060 Preventive Medicine - Policy and Strategies (2000), MPH 5267 Principles of Health Care Quality Improvement (1999).

[1] Fetherstonhaugh, D. Ibrahim, J. Rayner, J. McAuliffe, L. & Bauer, M. Failure in aged care: What measures can we use to predict it? (oral poster) International Forum on Quality and Safety in Healthcare. Glasgow, Scotland 27-29 March 2019. The full report is with Department of Health and Human Services (Victoria) titled "Australian Centre for Evidence Based Aged Care. Public sector residential aged care (PSRACS) performance measures development. Final Report 30 June 2018 La Trobe University'. It has not been publicly released.

[2] Ibrahim JE, Fetherstonhaugh D, Rayner JA, McAuliffe L, Jain B, Bauer M,. Meeting the needs of older people living in Australian residential aged care: A new conceptual model. Australasian Journal on Ageing 2020

3. **Knowledge of preparedness for emergency responses in aged care** due to internal and external disasters

    a. Research into[3] and development of resources[4] that prepare aged care homes for heatwaves

    b. Systematic review examining emergency evacuation in aged care homes[5]

    c. Reviewed and investigated incidents of premature death in aged care as part of the production of the Residential Aged Care Communique[6] and as an expert witness

What went wrong?

4. I have maintained an objective approach to this statement. However, the human misery and suffering must be acknowledged. This is the worst disaster that is still unfolding before my eyes in my entire career. I did not think we could sink any lower after the interim findings of this Royal Commission and yet we have.

5. In my opinion, hundreds of residents will die prematurely because people failed to act. There was a level of apathy, a lack of urgency and an attitude of futility which lead to absence of action, promotion of advance care plans and that care should be delivered in place. Responses when I voiced concerns were met with comments that 'everything is under control', 'there is no need to overreact and cause panic'.

6. We had enough knowledge to do better. We failed because when residents are treated as second class citizen there is an absence of accountability and consequences for those responsible for aged care in Australia.

7. I have briefly outlined below my view of what has gone wrong at a system level during this pandemic response. This provides a context for what needs to be done. It is easier to understand the offered solutions by defining the problem.

    - Failure to respect human rights that apply to the rest of the community—aged care residents are treated as Stateless citizens. The approach taken for the care of residents in any other setting would be considered discrimination on the basis of age and disability.

    - Failure to acknowledge that deaths could be preventable in aged care from COVID-19.

    - Failure to recognise and act on the findings of the Royal Commission's interim report. Government and sector remain in a state of denial as demonstrated by inaction.

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[3] McInnes Judith A., Ibrahim Joseph E. (2013) Preparation of residential aged care services for extreme hot weather in Victoria, Australia. *Australian Health Review* **37**, 442-448. https://doi.org/10.1071/AH13001. Available at https://www.publish.csiro.au/ah/Fulltext/ah13001

[4] Residential aged care services heatwave ready resource. Available at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/resi-aged-care-heatwave-ready-resource

[5] Willoughby M, Kipsaina C, Ferrah N, Blau S, Bugeja L, Ranson D, Ibrahim JE: Mortality in Nursing Homes Following Emergency Evacuation: A Systematic Review. *Journal of the American Medical Directors Association* 04/2017, DOI:10.1016/j.jamda.2017.02.005

[6] Available at: https://www.thecommuniques.com/aged-care

- Failure to consider and act on advice, warning signs and international precedents about catastrophic consequences, compounded by a mistaken belief that aged care in Australia was well prepared.

- Actions taken were underwhelming with a lack of critical appraisal and became self-congratulatory—those involved in the response are embedded within the underperformance of the aged care sector.

- Wrongly tasking the regulator (the Aged Care Quality and Safety Commission) to manage a health care emergency. Exacerbated by the absence of a regulatory model to address any type of emergency management.

- Failure to provide the same health response to residential aged care that was delivered to the rest of Australia.

- Long standing failure to conduct learn from previous disasters or to conduct disaster scenario simulation exercises to prepare aged care sector[7].

Contemporaneous information and advice

8. The information I provide in this statement is based on contemporaneous information. It is not hindsight or "knowing what to do after the fact". I formulated advice and strategies to mitigate the impact of COVID-19 on aged care—this is evident and verifiable by listening to our podcast (Prof Joe Covid 19 Aged Care Podcast) and my articles in the media. The information and ideas I present in this statement were developed and available in early May 2020.

9. I also raised my concerns about the potential catastrophic consequences of the pandemic through formal and informal channels on multiple occasions to State and Federal bodies in late March and early April.

10. On 3 April 2020, I wrote a formal letter to The Hon. Scott Morrison, MP, Prime Minister of Australia and The Hon. Greg Hunt MP, Minister for Health.

11. On 6 April 2020 I met with the Hon Richard Colbeck, Minister for Aged Care, his advisors and, Commissioner Janet Anderson (Aged Care Quality and Safety Commission) to discuss my concerns and outline potential strategies for improving Australia's pandemic management.

12. On 7 April 2020 I wrote a formal letter to The Hon. Greg Hunt MP, Minister for Health and Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians. I reiterated my concerns explained my reasoning and suggested a way forward.

13. The pandemic response for aged care was the subject of six working documents which I co-ordinated and authored. These were drafted between mid-March and the end of April. These documents were distributed by email when each was completed and all six were available to the following organisations by early May:

    - This Royal Commission

[7] Consider for example the 2009 bushfires in Victoria, and the 2010-11 floods in Queensland– where aged care preparedness was tested. Additional information about these events would be available from the jurisdiction.

- Aged Care Quality and Safety Commission
- Federal Ministers Office of The Hon. Greg Hunt MP, Minister for Health and Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians
- Department of Health and Human Services (Victoria)
- Safer Care Victoria

Aged care homes are particularly vulnerable to a COVID-19 outbreak

14. The deficiencies within the aged care system have been well documented, including in the interim report of this Royal Commission. These deficiencies include significant workforce and skills shortages, significant gaps in clinical care, a lack of transparency and a lack of accountability.

15. The Aged Care Quality and Safety Commission's report on the sector's performance between October and December 2019 identified that around 20% of facilities audited did not meet standards in 'safe and effective personal and clinical care', while 13% fell short on the measure of a 'safe, clean and well-maintained service environment'.[8]

16. The usual environment of aged care homes also contributes to the high risk of a COVID-19 outbreak. The environmental factors that contribute to this risk include: shared accommodation and communal spaces; the large number of people in a relatively small space; the physical environment being homelike and not clinical or designed for infection control; and that the workforce is trained to deliver personal care needs and not the clinical care required for a pandemic.

17. We had proof as early as March 2020 that aged care homes were particularly vulnerable to COVID-19. A study in the United States from the Centre for Disease Control and Prevention (CDC) reported on an outbreak at a care facility in King County, Washington.[9] In this outbreak, 34 of the 101 residents died. The CDC identified the following factors that contributed to the outbreak:

    a. Staff worked while symptomatic

    b. Staff worked in more than one part of the facility

    c. There was inadequate familiarity with and adherence to Personal Protective Equipment (PPE) recommendations

    d. Challenges to implementing proper infection control practices, including inadequate supplies of PPE and other items

    e. Delayed recognition of cases because of a low index of suspicion

[8] Aged Care Quality and Safety Commission, *Residential care sector performance – October – December 2020*, available at: Agehttps://www.agedcarequality.gov.au/sites/default/files/media/ACQSC_Sector_Performance_Data_October-December_2019%20final.pdf

[9] M McMichael, et al. 'Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington', *New England Journal of Medicine,* 27 March 2020.

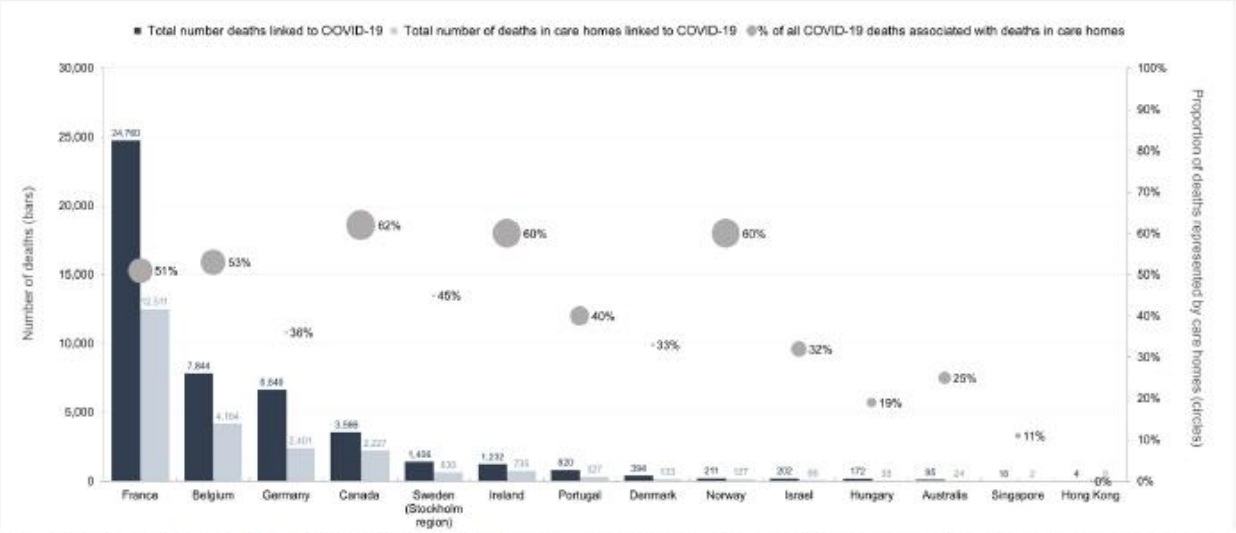
f. Limited availability of testing

g. Difficulties identifying persons with COVID-19 on the basis of signs and symptoms.

18. In addition to the evidence that aged care homes were particularly susceptible environments to outbreaks of COVID-19, there was early international evidence that the proportion of people dying from COVID-19 was significantly higher in care homes than in the general population. Residents of residential aged care facilities (RACFs) are often older people with multiple comorbid conditions and a significant proportion have cognitive impairment. Case fatality rates are higher for people with multiple morbidities.

19. The presence of cognitive and physical disability makes it harder to adhere to the fundamental infection control measures of social distancing and handwashing. Older people are often less able to voice their concerns if they are unwell and also less likely to complain. These factors contribute to the significant risk for the population living in RACFs.

20. Researchers at the London School of Economics[10] produced a mortality report (see table below) in early May that demonstrated the high mortality rates for people living in care homes. In France, Belgium, Canada, Ireland and Norway, 50% of all COVID-19 deaths were from people who lived in care homes. This research reinforced my view that residential aged care facilities cannot afford to be complacent and that a low level of community transmission still poses a very high risk to aged care residents.



Total number of deaths linked to Covid-19 in the total population compared to the number of deaths among care home residents.

21. The international experience made it clear that aged care homes were particularly vulnerable to an outbreak of COVID-19 and the residents of those care homes faced a far greater risk than the general population. More than standard techniques are required for the prevention of infection in RACFs and the protection of vulnerable residents.

[10] Comas-Herrera A, Zalakaín J, Litwin C, Hsu AT, Lane N and Fernández J-L (2020) Mortality associated with COVID-19 outbreaks in care homes: early international evidence. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 3 May 2020. available at the website - ltccovid.org.

22. In the remainder of this precis, I set out my views about how preparedness for and systemic responses to a pandemic could be improved to help protect the lives of people living in RACFs.

Outline of events and missed opportunities

February 2020

23. By the end of February 2020, knowledge about COVID-19 and potential risk to RACFs existed in the public domain:

- A pandemic due to COVID-19 is a real and apparent risk
- Highest case fatality rates from COVID-19 occur in older people with multiple comorbidities, amounting to approximately 15%, which is seven-fold greater that whole population rate[11].
- Australia's residential aged care system was
    - underperforming in ordinary circumstances
    - largely heterogenous with 2700 homes owned by 900 different providers
    - housing 200,000 frail older people with multiple comorbidities
    - ill equipped to manage infection control and infectious outbreaks, particularly as residents require personal care which necessitates close contact with staff
    - ill designed to manage infectious outbreaks, as housing includes shared bathrooms and bedrooms
- Aged Care Quality and Safety Commission Standards[12] that the regulator is required to monitor and audit compliance has one reference under Standard 8 Organisational governance stating organisations are expected to plan for and manage internal and external emergencies and disasters. There is no practical guidance on how this is to be achieved and pandemic management is not mentioned at all[13].
- Provision of care to older people is a health and clinical specialty as this population is heterogeneous and differ from middle aged adults in their response to illness and treatment. Pathophysiological changes in aging[14] will impact vital signs which makes COVID-19 screening approaches used for the general population less relevant for older people. Consequently, infections are more likely to be missed in people living in a RACF.

[11] Wu Z and McGoogan JM. Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention. JAMA Feb 24 2020

[12] See Page 169 Available at: https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V9

[13] The only "Relevant Resources and references" cited for use in the current environment is the National Health and Medical Research Council (2010). Australian guidelines for the prevention and control of infection in healthcare

[14] Ibrahim JE, Aitken G, Ranson DL. Pathophysiology of Aging: An Overview of Specific Pathophysiological Changes in Elders. In: Collins KA, Byard RW (eds.) Geriatric Forensic Medicine and Pathology. [Online] Cambridge: Cambridge University Press; 2020. p. 19–29. Available from: doi:10.1017/9781316823040.003

- To address this issue, specific guidance for identifying possible COVID-19 infections in RACFs would need to be developed.

24. The National COVID plan[15] was silent on known gaps in the aged care system. On page 17 there is this statement *"Additional strategies to support at-risk groups may be required (e.g. people with underlying illness, people with immunocompromised conditions, aged care, infants, Aboriginal and Torres Strait Islander peoples, remote communities)."*

25. There was not an articulated strategy specific for this high-risk population (older people with comorbidity) in a high-risk setting (aged care homes). Coordinated national expertise for aged care was missing. This could have been addressed if a core national unit was established. This is explained further below.

By the end of February, we should have been

a. Involving experienced senior clinical and managerial experts in the care of older people in residential aged care settings in pandemic planning efforts

b. Considering the development of specific guidance for identifying possible COVID-19 infections in RACFs. This is described below.

March 2020

26. In March 2020, international tragedies were unfolding in high income OECD countries like Italy, Spain, France and the United Kingdom. However, in my view pandemic response planning for RACFs was not apparent to the general public or sector as a whole.

27. On **3-March**, New South Wales Health identified an aged care worker with COVID-19 at the Dorothy Henderson Lodge.

28. On **6-March 2020** an Aged Care COVID-19 Preparedness Forum was held in Canberra[16]. Hosted by the Federal Government Chief Medical Officer, Professor Brendan Murphy and Minister for Senior Australians and Aged Care, Senator the Hon. Richard Colbeck. The official media release is relatively brief; however, a fuller report is available from the Victorian Healthcare Association[17]. I have not been able to source an official report from the forum and am uncertain if one if publicly available. A wide range of issues were raised, and it appears a commitment to undertake further, specific work was made. If the issues identified had been addressed, Australia would have been far better prepared.

29. It appears Australia's emergency response was reliant on our new regulatory body the *Aged Care Quality and Safety Commission,* which is in formative stages, still in transition and has no experience in public health emergency response. The Commission is still consolidating its three different functions of accreditation, complaints management and integrating the duties the Commonwealth Department of Health previously undertook up to 31 December 2019.

[15] Australian Health Sector Emergency Response Plan for Novel Coronavirus. Commonwealth of Australia. Available at:

[16] Media Release A joint statement from the Minister for Aged Care and Senior Australians, Minister Colbeck, and Australian Chief Medical Officer, Professor Brendan Murphy. Available at https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/statement-from-the-aged-care-covid-19-preparedness-forum

[17] Available at: https://vha.org.au/news/vha-participates-in-covid-19-preparedness-forum/

30. The regulator is not equipped nor experienced with pandemic emergency response management. The regulator does not have a relationship with the sector that would be conducive to a productive partnership, given the power imbalance between the regulator and provider. Finally, the regulator does not directly represent or act on behalf of the older people who reside in aged care.

31. I am not aware if any other regulatory agencies across the world that oversee aged care accreditation are fit for purpose in pandemic management. Health care pandemic preparation is not being led by the health accreditation agencies in Australia.

32. **11 March:** World Health Organisation announced COVID-19 outbreak as a pandemic.

33. **24 March**: ABC online releases media article on *Spanish nursing homes abandoned, residents found dead in beds as coronavirus worsens*[18].

34. **27 March:** Article formally published in the *New England Journal of Medicine*, one of the foremost medical journals in the world and widely read by medical practitioners. It describes the devastating impact of COVID19 in a care home. M McMichael, et al. 'Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington', *New England Journal of Medicine*, 27 March 2020.

35. The Aged Care Quality and Safety Commission undertook an audit for infection control that involved a self-assessment by providers. "*The tool will assist you to review the systems you have in place to manage the impact of infectious disease outbreaks and to act to identify, minimise and manage risks to the safety, health and wellbeing of your consumers.*"

36. I do not know how many RACFs completed the self-assessment and what information was received by the Commission. My observation of human behaviour is that providers would have been unlikely to provide a full and frank response, due to a fear of receiving a sanction. The questions asked are relatively broad and do not provide any guidance to assist with problem identification or suggested solutions.

37. Based on the information available at that time and the use of a rudimentary model assuming that only 5% of homes had an outbreak, only 50% of residents were infected and a fatality rate of 35%, we could expect 1750 residents to die.

38. In the first instance, there should have been a national audit of RACFs to identify and prioritise risks and, the organisation's capability to respond using existing information. This would identify those most vulnerable and least equipped to manage should an outbreak occur. I expand upon this below.

By the end of March, we should have been at least planning if not establishing

a. A national coordinating body specifically for residential aged care

b. A network for gathering field intelligence and advocates for RACF

c. A case management system with national risk rating and organisational response capability

[18] Available at: https://www.abc.net.au/news/2020-03-24/spain-elderly-people-dead-in-beds-coronavirus-worsens/12084892

d. Tailoring clinical pathways for screening and managing older people with COVID19

April 2020

39. The outbreaks and emergency responses at Dorothy Henderson Lodge and Newmarch House in Sydney were extensively covered in the media. However, no official record from government or health departments was forthcoming at this time about what happened, what lessons were learned, and how these lessons could be applied elsewhere.

40. **4-April,** the National COVID-19 Clinical Evidence Taskforce was established in early April with $1.5million grant from the Federal Government[19]. I also note that residential aged care was not part of the brief and that the reliance on summarising published empirical evidence would be a barrier to developing a knowledge base for aged care.

41. It became apparent from these outbreaks that a one-size fits all model would not succeed and each requires a different or proportionate response.

- There are at least three different situations based on the presence or absence of COVID-19 infection.
    - No COVID-19 in aged care home and no community transmission
    - No COVID-19 in aged care home BUT there is community transmission
    - COVID-19 outbreak in aged care home
- Complicated further by community and acute health care resources
    - Role and readiness of acute care hospitals with respect to aged care homes was variable
    - Local, regional and jurisdictional differences in approach
    - Availability of general practitioners and hospital outreach services

42. I do not have knowledge of what occurred in each State or Territory. What is clear is the need for State and regional teams to tailor responses according to the overall issues being faced and to identify whether the aged care home is able to draw on additional supports as needed. This is important as local knowledge and priorities need to be established based on the whole community.

By the end of April, we should have had

a. A national approach to visitation into aged care homes, instead a voluntary code was developed.

b. A standardised approach, tailored to aged care, for screening staff and visitors that was strictly observed, monitored and audited.

[19] Available at https://australia.cochrane.org/news/new-clinical-guidelines-covid-19-help-australian-clinicians-deliver-best-care

c. Each State and Territory establishing an aged care expert group to assist in planning and implementing relevant strategies.

May 2020

43. By May 2020, it was becoming evident that personal care workers were going to need more support and RACFs were not able to manage the outbreaks without substantial support.

44. There was growing evidence from media reports about the outbreak at Newmarch House and international experiences from high income countries. The increasing volume of empirical research evidence added to our existing body of knowledge. Also, the reality of the severity of the pandemic to the whole community was gradually being understood.

45. Templates and pro-forma documents were widely available to develop outbreak plans by now, many of these had been in circulation since March. What was not apparent was a design that was user friendly and achieved the desired goal.

46. There was an assumption that the person responsible at the RACF had the underlying knowledge required to understand and execute completion of an effective plan. Perhaps most concerning, was the assumption that the RACF outbreak plan coordinator had the authority and capacity to effect the changes needed and to gather any required resources. This creates a climate of 'we are on our own' and made the planning process more of a 'tick and flick'. Consider for example, how would you find an additional 20-30% staff when you work in a facility that is not always fully staffed? Services that managed to complete these plans well, had invested significant resource and person hours to prepare.

By the end of May, we should have had action to

- Support RACFs to develop their outbreak plans. This should have been resourced through the Federal government to an educational and training organisation which drew on the technical public health expertise and aged care managerial experience. Virtual training with small groups, providing modelled answers and solutions and sharing of knowledge between facilities would have assisted. Also, the lessons from the outbreaks that had occurred would have provided additional information and been useful case studies.

- Better gathering of field intelligence, better coordination and sharing of information should have been established. In the absence of empirical research data to determine the most effective approach, we rely on lived experience and expert opinion. By this stage we should have networked all RACFs into groups to share their experiences and innovations. Establishing a 'Community of Practice' would have achieved this with a small financial investment.

- Better training of care workers—this is very broad area. I specifically address only infection control and use of personal and protective equipment. This required Federal Government support along with aged care providers to commission an education and training organisation to deliver training. The training should have been competence based, that is participants are able to demonstrate skill acquisition. Delivery of self-directed online educational content is an implausible approach to skill acquisition. It achieves broad dissemination at low cost. Infection control nurse led training should have been nation wide—resources to achieve this include the over 30 schools of nursing throughout

Australia and the public hospitals. Given the information and skill set is discrete, a train the trainer model would have facilitated rapid distribution into aged care.

47. In my opinion, the notion that nothing else could have been done to prevent the situation currently unfolding in Victoria and New South Wales is completely unfounded.

Detailed description of actions to take for the aged care sector

Recommendation One: A core national unit for expert advice and management

48. In my opinion, there has been a lack of clear clinical advice to RACFs to help them manage their infection control measures and any outbreaks. There has also been a lack of clear leadership and coordination. To improve this situation in the advent of a pandemic, a core national unit, which is multi-skilled in aged care, health care and logistics should be established and supported by government.

49. I am not aware of all the various groups that have been set up for managing the pandemic—our lived experience as of 27 July 2020 would suggest these have not been sufficient to address the challenges we continue to confront.

50. The action taken as clearly stated in the joint statement of The Hon. Greg Hunt MP, Minister for Health and Senator the Hon Richard Colbeck[20] supports my conclusion:

    "The Australian Government is establishing a Victorian Aged Care Response Centre to co-ordinate and expand resources to tackle the challenge of COVID-19 in age care services. The Victorian Aged Care Response Centre will bring together Commonwealth and State government agencies at the State Control Centre in Melbourne in a co-ordinated effort to manage the impact of the pandemic across facilities".

51. In my opinion, this was very late in coming and it remains an incomplete response for Australia.

52. A national coordinating body for residential aged care should have been already established and I called for this in March[21].

53. The core national unit could act as a national coordinating body for the COVID-19 response in aged care. This unit, through a network of qualified personnel could have an 'on the ground' presence in every aged care home in Australia and have access to the appropriate logistics teams. Case managers could liaise with the 'on the ground' presence and provide information and advocacy to the core national unit.

54. Through this network real time information could be fed up to the core national unit which would be able to assist directing resources and providing clear clinical advice to RACFs and government. Information sharing between RACFs could also be facilitated through this network.

[20] Available at: https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/victorian-aged-care-response-centre
[21] Available at https://hellocaremail.com.au/saving-aged-care-will-save-our-souls-and-society/

55. A core national unit could develop national policy about what to do when COVID-19 occurs in a RACF and to assist our understanding from experiences in Australian and internationally.

56. The guiding principles should be to: save lives, maintain a humane society and focus on practical steps. Furthermore, it is imperative to understand that success requires a team that demonstrates; discipline, moral legitimacy, well-defined and well-articulated objectives, a clear chain of command, acting constructively, and being free of partisan interests.

57. The group operates and feeds into the established structures of the Australian Health Protection Principal Committee (AHPPC) and National Cabinet.

    - It includes expertise that understands the resident population, the aged care setting, the operational aspects of managing aged care and the health experts. A range of experts are required—an essential criteria in recruiting these participants is to have persons who have on the ground experience.
    - The table below gives a sense of the personnel required to contribute. Some may argue that the existing stakeholders and peak bodies as exemplified by the National Aged Care Alliance (NACA) would address this issue. While NACA comprises of approximately 50 organisations, it does not cover the range of expertise required for an emergency pandemic management response. The representatives are the senior organisational managers—not usually the staff on the ground.

      Table of personnel required to provide input for aged care COVID-19 response

RACS executive	Infection Control Nurse	Office of Public Advocate
RACS management	Infectious Diseases medical specialist	Community Service Providers
RACS nursing	Geriatric Medicine medical specialist	Consumer representative
RACS peak body	Gerontic Nursing	Severe Behaviour Response Team
Aged Care Safety Commission	Emergency Medicine Physicians	Primary Healthcare Network
RACS quality co-ordinators	Palliative Care	General Practitioner
	Public Health	Ambulance Service
		Funeral Directors

58. An executive group would be required and working parties established to address the major issues. Some of the issues were detailed on 6-March 2020 at an Aged Care COVID-19 Preparedness Forum, such as:

    - Clarify the role of aged care providers, state and territory governments and the Commonwealth in preparing for and responding to COVID-19
    - Increase delivery of infection control and procedures training
    - Establish communications package directed at aged care workers, with practical advice on how to feel protected and prepared

- Aged care staff working casually across a number of providers
- Determining whether or not to transfer a resident with COVID-19 to hospital
- Need for advice on the proper use and removal of PPE

Recommendation Two: A network for gathering field intelligence and advocates for RACFs should have been established.

59. We introduce an advocate into every aged care facility to be the eyes, ears, hand and heart for responding to COVID-19 pandemic. This is a person who is visible and present in each and every aged care facility.

    - A person who is trusted, that is, not connected to aged care sector, the providers or the Commission. The presence of a person who is external to these stakeholders will instil confidence in families, aged care staff and the community.
    - A person whose sole purpose is to promote and protect aged care services from COVID-19 and save lives.
    - A person who is an advocate to represent the needs of the staff to do their job, rather than be representing the financial security of the provider.
    - A person who reports daily providing essential field intelligence to assist the national effort in pandemic management.
    - A person who is able to identify areas of need and escalate, so that essential actions are taken.
    - A person who is able to support efforts to maintain morale, address issues around workforce, pandemic preparation, promote adherence to guidelines and reinforce a culture focussed on saving lives.

60. With approximately 2700 facilities in Australia, it is possible for each and every one to be reporting their operational status every day. Ideally this would involve engaging a new workforce independent of the regulator which reports into the existing public health structures. Preventing deaths requires prompt, accurate, reliable information from every site.

61. A national viable model could comprise of 100 personnel. One field advocate for 30 facilities, reporting to nine co-ordinators (one for every 300 facilities) who report to the response commander. This information is provided to aged care taskforce members who report to the Minister and advisory team and then into the established broader pandemic response structures. This concept is scalable and could operate in a virtual environment. The field advocate would liaise with a nominated member of RACF staff, a resident and a family member to gather a discrete set of critical information inform and monitor local responses.

62. The skill set and knowledge for the advocates could be rapidly imparted and supported. Protocols to support reporting of field intelligence could be quickly constructed, the capability to collate and analyse data already exists. Staff could have been sourced from Australian Defence Forces, senior nurses or allied health professionals, or the State and Territory Public Advocate.

63. At the very least this approach could have been used for the aged care homes ranked in the top 20% risk category, that is approximately 540 RACFs. A workforce as little as 30 persons would be required.

Recommendation Three: Case management, risk rating for vulnerability and organisational response capability

64. An overview that risk rates the existing residential aged care services should be done, describing their potential vulnerability to an outbreak during the pandemic, relationship to existing clinical services and organisational capacity to respond.

65. There is a significant amount of data held by government agencies including the Aged Care Quality and Safety Commission and the Commonwealth Department of Health as part of their usual reporting processes. This includes health departments examining individual facility's hospital utilisation per annum, past non-compliance from audits by Aged Care Quality and Safety Commission and, data about residents from the Aged Care Funding Instrument (ACFI).

66. This information would enable a profile to be completed for all aged care facilities addressing:

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

67. The information could be collated and used to develop a risk register according to each profile of every RACS. It would inform structured and objective decision-making. There is currently sufficient data collected to enable this to occur.

68. The specific vulnerabilities of each RACF, as well as sector wide risks, could be identified and acted upon if this risk profiling took place. Centralised gathering of data and sharing this with a core national unit would significantly assist the management of the pandemic and save lives.

69. The Table below describes some of the elements that could be considered for this type of model. The science and art of risk management is well established and not a novel concept. This rudimentary model I constructed alone and at short notice in March. The usual steps with any risk management model is to consult with a range of people, discuss, debate, pilot and refine the variables and categories to identify those that are plausible and discriminating. This approach would enable grading all 2700 RACF into three categories and to prioritise appropriate support for preparation.

Variables	**Definition**	**Rationale**	**Risk rating**		
Internal RACS Factors			**Low**	**Medium**	**High**
Size	Number of beds	Identifies total resident population at risk	<30 beds	31-60	>61
Location	ABS remoteness	Proxy measure for level of isolation and perhaps lower likelihood of infectious outbreak	Metro	Regional	Remote

		Proxy measure for availability of clinical services and General Practitioners			
Ownership	Public NFP Private	Proxy for staffing levels Proxy for proportion of professional staff clinical staff (only PSRACS have a consistent level of nursing staff)	PSRACS	NFP Private (operates multiple sites)	NFP Private (single operator)
High care	Proportion of residents with significant personal care needs	Proxy for vulnerability and perhaps mortality	<33%	34-66%	>67%
Respite care	Number of respite care beds	Proxy for community transmission of infection Proxy for surge capacity			
Number of rooms	Single rooms Dual occupancy	Proxy for transmission of infection Proxy for ability to achieve isolation	All single	90-60%	>50% single
Dementia	Proportion of residents with dementia	Proxy for transmission of infection—more residents with dementia more likely to increase ability to contain Proxy for ability to achieve isolation Proxy for increased need of clinical care—isolation and absence of family during shutdown and climate of anxiety more likely to increase incidence of delirium or BPSD	<33%	34-66%	>67%
Staffing level	Proportion of casual staff	Proxy for potential workforce shortage	10%	11-20%	>21%
Staffing level	Proportion of RN	Proxy for potential workforce capability to implement requisite interventions			
Sanctions	History of sanctions or unmet	Proxy for organisational culture and capability Infection control Clinical			
External services					
General practice	Ratio of General Practitioners to population in the geographic region	Proxy for potential availability of additional clinical support Perhaps only for regional and remote services			
Public hospital	Proximity of RACS to a public hospital	Proxy for potential availability of additional clinical support graded according to distance between the two			
Public hospital	Bed number and occupancy	Proxy for potential to meet surge capacity, could calculate relative to potential number of infected residents			
Residential in reach		Proxy for existing supports for RACS	On site service	Consulting only	No service
Emergency department level	Affiliated ED with RACS Levels 1-4	Proxy for ED capacity, higher level is more capable			
Ambulance	Level of availability	According to potential response time Likelihood of being available			

Recommendation Four: Tailoring of clinical pathways for screening and managing older people with COVID-19

70. By March, a clinical expert group should have convened to consider screening and management of older persons with COVID-19 infections. This would be done in consultation with public health and infectious diseases specialists. Geriatric medicine specialists and gerontic nurses would inform existing initiatives and develop strategies tailored for older people. Clinical consensus would be the most likely approach, given the paucity of empirical evidence.

71. Formation of expert clinical teams across Australia to co-ordinate answering the important clinical questions such as:

    - Decision-making, the intersection between general practitioners, geriatric medicine specialists and the acute hospital specialists
    - Transfer to acute care or shelter in place
    - Clinical features to assist with escalation of care
    - How the known pathophysiological changes with ageing impact on screening criteria and treatment options
    - Management of persons with dementia, responsive behaviours due to social isolation and/or COVID-19 infection

72. I led the production of the six working documents which used a model of (1) rapid development of an issues paper, (2) rapid dissemination to a group of 10-25 clinical experts with different skills and experience, (3) collation of comments and integration into a final report and, (4) distribution to agencies responsible for pandemic management.

73. My experience was one of collaborating with highly motivated, caring and insightful individuals willing to contribute freely in their own time. This approach could have been rapidly expanded and multiple groups created, each assigned a specific question to answer. This approach is not novel and follows some of the principles for conducting systematic reviews and achieving consensus. To achieve a high degree of scientific rigour requires infrastructure and funding.

Recommendation Five: Local management plan

74. Each RACF should be supported to develop a local management plan for the occurrence of an outbreak (COVID-19 or non-COVID-19 related) in the facility. Ideally, this action plan would be informed by advice from the national unit and RACFs would be supported by appropriately trained personnel to help develop the plan for the specific requirements of the facility.

75. The plan should be developed in conjunction with a facility's local hospital, General Practitioners (GPs), palliative care services, Residential-in-Reach services and pharmacy. The plan should include plans for the aged care workforce. The requirements for personal protective equipment (PPE) should be identified and the plan should include provisions for access to additional supplies.

Recommendation Six: Workforce and workforce training

Workforce

76. There is a need for hiring and rapid training of new staff to work in RACFs. This could be done with RACFs working together to create a staff bank. Sources of such staff may be existing staff who work less than fulltime, perhaps students (especially health care students).

77. All new staff will need training prior to commencement to upskill and gain the basic skills and knowledge. Their duties should be limited to account for their lack of experience.

78. RACFs need to have contingency for increased staff should a facility become COVID-19 positive, to account for increased staffing needs and staff becoming sick. There needs to be clear communication with new and existing staff regarding possible new roles should this occur.

79. One option is whether RACFs should aim to have continuity of shifts to minimise the number of people coming in and out over a 24-hour period (e.g. create 12 hour shifts). Whether this is feasible given the potential workload and risk of fatigue is debatable. This idea would require advice and consideration by the staff affected.

80. Strategies for the aged care workforce have been reviewed prior to the pandemic. To date, the approach has lacked a sense of cohesion or shared responsibility national. The current surge workforce arrangements are better than nothing. One cannot help but wonder how circumstances may have been different if something had been implemented sooner or even better, if a national approach had been in place prior to the pandemic.

Workforce training

81. From now, training should be provided to all RACFs about COVID-19 or any future pandemic and their roles and responsibilities. This should include training on correct use of PPE, hand hygiene, social distancing within RACFs and infection prevention. Regarding COVID-19 positive patients, staff should be educated about identification of COVID-19 positive patients, assessment, management, transfer options and infection control safety.

82. A rapid evaluation of existing training and its impact should be conducted. Based on that evaluation a revised standardised national program should be instituted, perhaps through the University given their spare capacity.

83. Staff will require clear communication regarding possible new roles including upskilling to manage COVID-19 positive residents. Consideration should also be given to training locum GPs, who are being increasingly used by RACFs, to create a standardised approach for PPE and hand hygiene practices, and screening and management of COVID-19 patients to minimise transmission between RACFs. This training could be delivered in an online format, including utilising existing Government resources that have been made.

Recommendation Seven: Managing the impact of social isolation on people with cognitive impairment

84. Isolation and visitation restrictions in RACFs disproportionally impacts people with dementia or cognitive impairment. These impacts include the loss of informal supports and care provided by family members or friends; restrictions on diversional activities and ability to move freely around the facility; and isolation from family and friends limits the ability their ability to help identify subtle changes in behaviour suggestive of an evolving delirium. These factors can have a significant impact on a person with cognitive impairment and cause an acceleration of their behavioural and psychological symptoms of dementia (BPSD) and a deterioration of their general health.

85. It is possible that an increase of people experiencing BPSD in a RACF could lead to an increase in the use of restraints. The best care dictates non-pharmacological management of responsive behaviours. However, these measures are resource intensive and hard to implement. Without

additional resources this would increase the already significant burden on the workforce and may result in increased absenteeism.

86. The possible ways to manage this impact include staff education and training in the prevention and early recognition of increased BPSD; increased care staff to support current staff and provide tailored care for people with dementia or cognitive impairment; supporting families to care for their older relatives at home; and the use of technology to help residents to connect with their family, friends and health professionals. To prevent the health of people with dementia or cognitive impairment deteriorating during a lockdown or visitation restrictions, increased staff and resources are needed to replace the significant care usually provided to residents by their friends or family.

Recommendation Eight: Establish communities of practice

87. Communities of Practice are a collection of people and organisations who 'share a concern or passion for something they do and learn how to do it better as they interact regularly'.[22] It involves:
    - a collaboration of people who seek to improve or complete something more effectively
    - decreasing complexities associated with using multiple organisations' resources during times of crisis
    - members sharing their experiences and knowledge in free-flowing, creative ways that foster new approaches to problems, raising the industries standard more efficiently
    - aiming to solve problems, develop skills and transfer practices.

88. The COVID-19 pandemic presents the aged care industry with an unprecedented challenge. Residents of aged care facilities are the most vulnerable group in Australia to develop complications and die from this virus. A Virtual Community of Practice (VCoP) for the aged care sector would enable staff, external experts and stakeholders to communicate existing and potential problems during community lockdown.

89. An increase in knowledge sharing would increase sector capacity. Additionally, it would decrease the complexities associated with using multiple organisations' resources during times of crisis.

Recommendation Nine: Aged care remains at high risk of catastrophic consequences and should be a national priority

90. There is little community and professional understanding around the magnitude of risk that confronts aged care. There are two statistics that convey the scale.

91. First, RACF residents account for 1% of the population and yet 50% of all COVID-19 deaths.

92. Second, the risk of an outbreak in an aged care home is extremely high with very low rates of community transmission. In the last week of July 2020, there are about 770 aged care homes in Victoria of which 87 (11.3%) have an outbreak. That is 30 times more than in the general Victorian population, where we have 9,000 cases across 2.4 million households (0.375%).

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[22]Wenger, E. (1998). Communities of practice: learning, meaning and identity. Cambridge: Cambridge University Press.

Recommendation Ten: Establish a formal inquiry to establish what happened, why and how we can learn from our experiences in Australia from 1-Jan 2020.

93. We learn by identifying and owning our mistakes. Failure to do so on this occasion reinforces the dysfunctional and pathological culture of lack of transparency and accountability that continues to surround aged care. There are lessons about pandemic management and new insights into the aged care system. A recently published study examining experiences in California USA[23] reported *"nursing homes with 5-star ratings were less likely to have COVID-19 cases and deaths after adjusting for nursing home size and patient race proportion".*

94. We learn most about individuals, teams, organisations and systems of care when they are placed under stress. The pandemic has placed an enormous stress, tested us and we have come up short.

95. A full judicial inquiry is required to identify what went right and what went wrong (and why) and how we can do better.

Conclusion

96. According to data published by the Department of Health on 30 July 2020 there has been a total of 189 deaths in Australia from COVID-19.[24] This same data records 105 deaths from COVID-19 in residential aged care facilities. With over 55% of COVID-19 deaths occurring in the less than 1% of the population who live in a RACF, it is clear Australia is among some of the worst countries in the world in terms of protecting some of our most vulnerable people.[25]

97. In my opinion, if the actions set out were implemented, resourced properly and supported by strong political leadership the aged care sector would be much better prepared for further outbreaks and future pandemics.

98. What is beyond doubt is Australia's aged care system is completely broken and needs to be completely reset. Older people continue to die needlessly because of the ongoing systemic failures.

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[23] He, Mengying et al. Is There a Link between Nursing Home Reported Quality and COVID-19 Cases? Evidence from California Skilled Nursing Facilities. Journal of the American Medical Directors Association, Volume 21, Issue 7, 905 - 908

[24] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#cases-in-aged-care-services

[25] Australian Bureau of Statistics, 3101.0 - Australian Demographic Statistics, Dec 2015 available at: <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Dec+2015>; Australian Bureau of Statistics, 4430.0 - Disability, Ageing and Carers, Australia: Summary of Findings, 2015, available at: <https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/4430.0Main%20Features1042015?opendocument&tabname=Summary&prodno=4430.0&issue=2015&num=&view=>.

Appendix 1: Contemporaneous documents in the public domain

1. Prof Joe Covid-19 Aged Care Podcast[26] we produced 29 episodes drawing on a range of national and international experts. These were released during March, April and May 2020 with the goal of assisting aged care homes to be better prepared.
2. Residential Aged Care Communique
    a. April 2020 Special Edition COVID-19 and aged care
    b. May 2020 COVID-19 follow-up edition
3. RAC Communiqué Podcasts[27]
    a. Episode #1: Special Edition COVID-19 and aged care
    b. Episode #3: Brooklyn, bugs and a blind eye
    c. Episode #4: COVID-19 follow-up edition
4. Hello care[28]: 28-March 2020 Saving aged care will save our souls and society
5. The Age and SMH[29] 30-April 2020 *Why the PM is wrong to push for visits to nursing homes*
6. Editorial COVID-19 and residential aged care in Australia. *Australian Journal of Advanced Nursing*[30].

[26] Available at https://www.profjoe.com.au/
[27] Available at https://www.thecommuniques.com/podcasts-residential-aged-care
[28] Available at https://hellocaremail.com.au/saving-aged-care-will-save-our-souls-and-society/
[29] Available at https://www.smh.com.au/national/why-the-pm-is-wrong-to-push-for-visits-to-nursing-homes-20200429-p54o4p.html
[30] Ibrahim JE. COVID-19 and residential aged care in Australia. *Australian Journal of Advanced Nursing*. 2020 Jun-Aug;37(3):

Appendix 2: Documents provided to the State and Federal Government Departments, Federal Health and Aged Care Ministries and the Aged Care Quality and Safety Commission

The following six documents were provided as attachments to emails that I initiated to a wide range of recipients employed in organisations responsible for our pandemic response. These comprise a total of approximately 90 A4 pages of material generated through existing published literature, consultation with colleagues and peers in aged care.

Each report was developed with the sole objective of contributing to efforts to prevent deaths and promote humane care for older people. None of the contributors were paid.

1. [1] Scenario DHHS COVID (JEI23MAR1045h)
2. [2] Response to COVID-19 Scenarios COLLATED (1330h 26MAR20JEI)
3. [3] Priorities for RACS response to COVID (31Mar20 1430h JEI)
4. [4] Screening for Covid in older people (JEI19Apr1100h)
5. [5] COVID and RACS and PWD FINAL JEI 28 April 2020
6. [6] COVID Disease Trajectory Guidance Older Person(JEI1MAY20)

Appendix3: Aged Care Quality and Safety Commission Risk Questions 6th March 2020

The Aged Care Quality and Safety Commission developed a set of standard risk-based questions that will be asked on commencement of a performance assessment[31].

There are eight question, the only one explicitly directed at COVID19 pandemic response is the final one which reads:

> *What action has the service taken to assess and minimise infection-related risks for the care of aged care consumers including the impact of a potential coronavirus (COVID-19) outbreak?*

[31] Available at: https://www.agedcarequality.gov.au/providers/assessment-processes/risk-based-questions#residential%20services%20%E2%80%93%20riskbased%20questions

Appendix 4: VHA participates in COVID-19 Preparedness Forum on 6 March 2020[32]

Information is direct quote from website.

"The Government to:

- Clarify the role of aged care providers, state and territory governments and the Commonwealth in preparing for and responding to COVID-19
- Ensure the availability of Personal Protective Equipment for aged care services
- Consider increased delivery of infection control and procedures training
- Ensure ongoing communications including a forum focused on home and community care
- Establish communications package directed at aged care workers, with practical advice on how to feel protected and prepared
- Develop strategies to maintain and retain the workforce, and to develop options for an aged care surge workforce capacity which may involve the increasing the hours of visa holders, lifting regulatory arrangements around general practice and the use of graduates and students
- Deliver a broad communications campaign for the community.

The VHA also noted some other key points:

- The issue of some aged care staff working casually across a number of providers
- Determining whether or not to transfer a resident with COVID-19 to hospital – updated Advance Care Directives needed as to the persons end of life wishes
- No health care worker has caught COVID-19 while using PPE
- Need for advice on the proper use and removal of PPE
- If using PPE in contact with a COVID-19 resident there is no need to self isolate – you are not considered to have caught the infection
- Specific workshop for the home care sector required
- Surge workforce to include higher number of RNs with infection control expertise (perhaps in local regions)

Hospital transfers
Professor Murphy outlined in Senate Estimates on 4 March 2020 at what point a resident should be transferred to hospital: "The point would be when it's felt that they need hospital care—if they need treatment that only a hospital can provide. They might have a secondary infection. They might be physically quite unwell. They might need respiratory support. In those circumstances they'd be transferred to hospital. If they just had a bit of a fever and a cough and they were otherwise well, we would hope that most facilities would be prepared to look after them there, because it's in their interest."[33]

[32] Available at: https://vha.org.au/news/vha-participates-in-covid-19-preparedness-forum/
[33] Available at: https://www.aph.gov.au/Parliamentary_Business/Hansard/Hansard_Display?bid=committees/estimate/66ba932e-d456-4ae0-a126-3505810be0f8/&sid=0005