Witness Statement of Dr Melanie Wroth

Name:	**Dr Melanie Wroth**
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Occupation:	Chief Clinical Advisor at the Aged Care Quality and Safety Commission
Date:	27 July 2020

1 This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety (**Royal Commission**).

2 This statement is true and correct to the best of my knowledge and belief.

3 I make this statement on behalf of the Aged Care Quality and Safety Commission (**ACQSC**), and I am authorised to do so.

4 I currently hold the position of Chief Clinical Advisor at the ACQSC.

5 I provide this statement in response to a Notice to Give dated 20 July 2020 from the Royal Commission.

6 I make this witness statement based on matters within my own knowledge, the books and records of the ACQSC that I reviewed and having made inquiries of its officers and employees.

7 This statement has been prepared with the assistance of lawyers in response to and in compliance with a notice to provide a statement. It is produced to the Royal Commission into Aged Care Quality and Safety on the basis that it will be tendered and received in evidence by the Royal Commission pursuant to that notice and on the basis that the statement will be treated as evidence which is subject to section 6DD of the *Royal Commissions Act 1902* (Cth).

Professional background

8 I have held my current role of Chief Clinical Advisor since May 2019. My responsibilities in this role are outlined in response to question 3 below.

9 I have been involved in providing medical care for older Australians since 1990 and currently hold the following part-time roles:

(a) Senior Staff Specialist in Geriatric Medicine, Royal Prince Alfred Hospital (since 2005);

(b) Senior Member (Professional) – Guardianship Division, NSW Civil and Administrative Tribunal (previously Guardianship Tribunal NSW) (since 2010); and

(c) Clinical Senior Lecturer, Central Clinical School, Faculty of Medicine and Health, University of Sydney (since 2019).

10 I have also previously held the role of Consultant and Hearing Member for the Medical Council of NSW (previously the NSW Medical Board) (from 2000 to May 2019).

11 I hold a Bachelor of Medicine and Bachelor of Surgery from the University of Sydney and am a Fellow of the Royal Australasian College of Physicians.

3) Outline your role as Chief Clinical Advisor at the Aged Care Quality and Safety Commission, including during the COVID-19 pandemic, and your role with respect to Newmarch House.

12 The *Aged Care Quality and Safety Commission Act 2018* (Cth) (**ACQSC Act**) provides for the Commissioner to appoint a Chief Clinical Advisor to assist the Commissioner in the performance of the Commissioner's functions.

13 The position of Chief Clinical Advisor at the ACQSC was established to help ensure that all of the ACQSC's functions are underpinned by contemporary clinical evidence. The Chief Clinical Advisor provides clinical information, feedback and advice to the Commissioner and within the ACQSC to assist with activities and resources for Commission staff across all areas. The Chief Clinical Advisor identifies areas of risk where aged care providers would benefit from stronger clinical guidance and helps manage these risks by:

(a) ensuring the ACQSC has access to high quality aged care expertise;

(b) identifying areas of risk where aged care providers would benefit from stronger clinical guidance;

(c) raising awareness and disseminating best practice evidence in the management of high prevalence high impact risks in the clinical care of consumers;

(d) providing contemporary evidence-based and best practice clinical advice for aged care services;

(e) working on a sector-wide basis to help raise awareness of clinical issues and areas of high risk in aged care, and promote better practice; and

(f) engaging with the ACQSC's key stakeholders including the Aged Care Quality and Safety Advisory Council (of which I am an ex officio member), professional groups, peak bodies and professional associations.

Role during the COVID-19 pandemic

14 During the COVID-19 pandemic, in my role as Chief Clinical Advisor, I have been actively engaged with key stakeholders across the aged care sector including the Commonwealth and State health departments, members of the medical, nursing and allied health professions, aged care consumer advocates, provider peak bodies and aged care service providers managing active COVID-19 cases to assist, co-operate with, or advise on responses to the pandemic. During this period, I have been engaged in a range of activities including having:

(a) provided initial briefings to the Commissioner and executives of the ACQSC on the emerging pandemic and the potential impact on the aged care sector in Australia;

(b) continued to provide briefings to the Commissioner and the ACQSC Executive on emerging issues in the sector such as aged care staff who work across multiple services, and asymptomatic cases;

(c) provided advice to the Commissioner and ACQSC staff on sector-wide guidance and responses to the COVID-19 pandemic;

(d) provided advice to the ACQSC case management team to support them in providing guidance to service providers concerning their response to outbreaks at services across Australian jurisdictions including, for example, at Opal Bankstown and Newmarch House, and currently, the many services which are affected in Victoria;

(e) provided guidance to the aged care sector through the development of guidance materials such as the 'Are you alert and ready – Homecare services' advice, the 'Are you alert and ready – Residential services' advice, and a letter to all residential services regarding screening of people entering the facility;

(f) provided feedback and contributed to materials produced by other stakeholders; and

(g) provided clinical talks including, by way of example, a talk to the Sydney Local Health District aged care department and local service providers on learnings and experiences from the pandemic, and webinars with the Older Persons Advocacy Network on protection during a pandemic and on dementia care during COVID-19 restrictions.

Role with respect to Newmarch House

15 During the outbreak at Newmarch House, working alongside the Executive Director of the ACQSC's COVID-19 Taskforce, I:

(a) actively engaged with staff at the facility to:

(i) enable the ACQSC to understand the circumstances in which the outbreak was developing; and

(ii) contribute to clinical advice and guidance on how the facility could respond to and manage the outbreak;

(b) provided clinical advice to the ACQSC staff to support the ACQSC's response to the outbreak;

(c) regularly attended outbreak response meetings that were being held between representatives from the approved provider, NSW Health, the Commonwealth Department of Health and the ACQSC to help Newmarch House manage the response to the pandemic. This included discussion of:

(i) the risks to individual residents;

(ii) the risks to facility staff; and

(iii) the risks in hospitalised residents returning to the facility; and

(d) reviewed and provided extensive feedback on the development of an Infection Outbreak Management Plan developed by Dr Bradley Forssman (Director of Public Health and Functional Area Coordinator, Nepean Blue Mountains Local Health District). This included feedback in relation to cohorting and monitoring of clinical risks.

4) Describe the basis of your recommendation on or around 15 April 2020 with respect to the separation of infected residents at Newmarch House.

16 On or around 15 April 2020, and in ongoing meetings over the ensuing weeks, I was engaged in discussion about the need to separate infected residents from non-infected residents. It is important to be aware that the non-infected residents are not initially distinguishable from those incubating the virus as both of these groups test negative until those incubating return a positive test with or without symptoms. This separation could have been achieved by removing infected residents or residents so far testing negative from Newmarch House, or cohorting the infected residents in a separate area of the facility away from the non-infected residents. The recommendation to separate residents reflected my view that it would minimise the risk of transmission to non-infected staff and residents of Newmarch House while providing better opportunities for acute care to be provided to infected residents as and when required by staff deemed proficient in the use of personal protective equipment (**PPE**) to protect themselves. The need, in my view, to separate the infected and non-infected residents was informed by and took into account the following factors:

(a) General infection control principles that infectious individuals should be removed from proximity and contact with non-infected individuals, as occurs in the broader community during an infectious disease outbreak;

(b) My understanding of the complex environment in a residential aged care setting where there are:

(i) a large number of episodes of close personal contact with residents by staff who may lack experience in infection prevention and control (**IPC**) and PPE use;

(ii) large numbers of people living and working in close proximity;

(iii) large numbers of surfaces being touched frequently by people on site;

(iv) shared use of equipment and spaces; and

(v) some residents who may be unable to remember or comply with isolation and infection control processes;

(c) The particularly high risk of severe illness and mortality in the elderly;

(d) The number of infected staff and residents as at 15 April 2020;

(e) The rate at which further residents were being infected;

(f) The number of agency staff working at short notice in an unfamiliar service with no knowledge of individual resident risks and needs, and lacking experience in PPE use;

(g) The rate at which further staff were being infected, which was an unacceptable risk in terms of workplace safety, further impeding the facility's ability to manage the number of infected residents, and suggesting failure of IPC;

(h) My observations on how outbreaks in residential aged care facilities had been occurring in international jurisdictions with failure to contain ongoing infection and the catastrophic outcomes;

(i) The right of residents to be protected as individuals;

(j) My general observations on the COVID-19 pandemic; and

(k) The principles and factors listed at paragraphs 18 and 19 below.

5) Do you consider that the position adopted with respect to hospital transfer or the internal or external separation of residents of Newmarch House who had tested positive to COVID-19 should be adopted in relation to future outbreaks? Provide reasons for your answer.

17 The aged care sector has learnt a lot from how the COVID-19 pandemic has impacted aged care services across Australia and internationally. This knowledge has helped and will continue to help guide the position that could be adopted in relation to any possible future outbreaks of COVID-19 in aged care.

18 The experiences to date of dealing with COVID-19, both in terms of its impact in aged care and more generally in the community, show that there is no one singular approach that should be adopted with respect to hospital transfers or externally separating residents of residential aged care facilities who have tested positive or negative to COVID-19. A decision must be made on a case by case basis, taking into account all relevant evidence and information and the available options at that point in time, with the core underlying principles being that:[1]

(a) non-infected residents must, as the first priority, be kept separated from infected residents;

(b) regard should be had to the best interests of each of the residents;

(c) infected residents should be able to receive the level of care they require at all times;

(d) there must always be respect for the wishes and desires of residents (both infected and non-infected) at that aged care facility;

(e) staff at an aged care facility should be entitled to work in a safe environment; and

(f) public heath orders or restrictions.

[1] Noting that for any given situation, some of these principles may be in tension and the weighting given to each of these principles may change over time.

19 The following factors are also likely to be crucial in determining the most appropriate response to a future outbreak of COVID-19 in a residential aged care facility:

(a) **The scope and scale of the outbreak**. The smaller the initial outbreak, the less likely it is that there will be a need to introduce significant changes to the living arrangements of residents. Similarly, a single infected staff member (who will immediately be removed from and kept away from the facility) is easier to manage than a single infected resident.

(b) **The health needs of infected residents and the ability of the facility to manage those needs**. As an outbreak develops, it may be the case that a number of the infected residents suffer serious health complications and distressing symptoms. Clinical decline can occur rapidly. It may be clinically appropriate for some residents to receive hospital care in line with their rights and wishes, or if their needs cannot be effectively or safely managed in the service. The level of clinical support available to each service is variable, and may be impacted by the location of the facility, the stage of the local outbreak, the availability of General Practitioners still prepared to visit the facility, and the availability of specialist “in-reach” services and other clinical support. In some circumstances, a facility may not be able to provide or source the level of acute care required for some residents.

(c) **The profile of residents at the facility**. Some residents, particularly those living with dementia or other medical conditions, may find it more difficult to comply with infection control protocols, such as requirements to remain in their rooms, to socially distance, and to maintain hand and environmental hygiene. This increases the risks of acquisition of infection and transmission to others. This also needs to be taken into account in determining whether caring for a resident on-site is appropriate.

(d) **Changes in the staffing profile at the facility.** For example, where regular staff are unwilling to work or are in quarantine after coming into contact with an infected resident (or staff member or being infected themselves), they need to be replaced immediately by other staff who could be agency staff. Agency staff often have no familiarity with the layout / design of the facility, the governance structure, the service’s systems and processes or the individual needs of each resident at that facility. They may also have received limited training in PPE use and have had no practical experience in its use. This makes managing the outbreak while continuing to provide safe care more difficult, and the risks higher to both residents and staff.

(e) **The capacity of the local hospital system**. This will vary with the extent of community cases at the relevant time. This may impact a hospital’s ability to manage incoming transfer of infected or other residents, especially if there are a number of such admissions.

(f) **The availability of alternative premises**. This includes private hospitals, vacant wings or floors in services, or empty buildings in other residential aged care facilities, and at times private homes where families wish to remove their loved one from the facility temporarily. The greater the availability of suitable alternative premises, the more scope for flexibility there is in managing the outbreak.

(g) **The design and capacity of the aged care facility including residents' rooms and facilities**. This will impact the ability of the facility to separate infected residents and non-infected residents. For example, it is significantly more difficult to create the necessary level of separation where the facility is designed to have shared rooms and/or bathrooms. Conversely, where a facility has cottage-style accommodation, residents can be more readily separated thereby reducing the risk of infections spreading across the facility. Where a facility is not operating at full capacity, this also provides it with a greater degree of flexibility to move residents around, making use of vacant rooms. Isolation areas can sometimes be set up in common areas that are unused in an outbreak setting.

(h) **The risk posed to staff at the aged care facility**. As outlined above, it is important that staff at an aged care facility are able to work in an environment that is safe and does not expose them to unnecessary risk of exposure to COVID-19.

(i) **The capacity and capability of the aged care facility to manage the outbreak.** This includes consideration of how well the aged care facility is responding to the outbreak and the degree to which there is confidence within the management of that facility that they can successfully manage the outbreak. Relevant matters to consider also include:

  (i) the ability of the provider to draw on and access further resources, such as additional staff, equipment or medical supplies, on short notice;

  (ii) staffing numbers need to support resident care and safe PPE use given the greatly increased time and physical burdens of frequent PPE changes, considering each resident may require up to 10 care contacts in a shift and some care requires two staff members to complete;

  (iii) how well trained staff are on IPC and the use of PPE. Correct PPE use sustained over many hours is difficult to maintain even by experienced medical and nursing staff, and requires constant vigilance. Minor breaches can allow viral transmission, and managing agitated, frightened, distressed or physically challenging residents can increase the challenges. This therefore requires robust education being provided to care staff prior to them starting on-the-ground work, including individual practical training; and

  (iv) how much the provider can maintain workforce oversight and capability, including in respect of management oversight, clinical oversight, education and IPC, and also how well they can maintain stability of processes and management of risks to staff and patients. Ongoing oversight of correct IPC and PPE use needs to take into account the challenges and risks when care staff with limited experience of PPE use are required to use PPE, donning and doffing numerous times a day, over many hours

(j) **The impact on non-infected residents**. Consideration needs to be given to the impact of the health needs of infected residents on the ability of the facility to care for the needs of non-infected residents in accordance with the Aged Care Quality Standards (**Quality Standards**). Where an outbreak causes considerable strain on resourcing at the facility, it may lead to a

reduction in the level and quality of care given to non-infected residents. Additionally, all residents often need to go into lockdown during the course of an outbreak. Prolonged lockdown for residents, including isolation in their rooms, may have increasingly detrimental impacts on their physical, mental and emotional health and wellbeing. Facilities should seek to minimise this impact to the extent possible and actively work from the earliest stages of lockdown to prevent it.

(k) **Ability to detect and critically analyse potential breaches of IPC and other systems.** A facility needs to be able to analyse and determine what can be changed or improved if there is evidence of potential ongoing internal transmission of infection, or risks to wellbeing generally.

6) To what extent do you consider residential aged care facilities are capable of providing or ensuring hospital-grade infection control and acute care?

20 Residential aged care facilities in my opinion do not have the capability to provide or ensure hospital-grade infection control and acute care in some clinical situations. As discussed in further detail in response to question 7 below, residential aged care facilities have a number of obligations under the Quality Standards that relate to infection control. Residential aged care facilities also have a number of obligations in respect of facilitating and providing certain clinical services.[2] Accordingly, there are positive obligations that exist on service providers to provide (or ensure the provision of) infection control and clinical care.

21 Many aspects of clinical care can be and are delivered safely and according to best practice in many aged care services. This is generally the case for residents with chronic and stable conditions that require such things as diabetic monitoring, wound care, anticoagulants, safe and timely medication delivery, monitoring of blood pressure, temperature testing, pressure area care, detection of deterioration, pain management and many aspects of palliative care. Some services manage urinary catheters, stomas, tracheostomy tubes, nasogastric tube and percutaneous endoscopic gastrostomy and radiologically inserted gastrostomy tube feeding. Some of this requires special training for individual residents' circumstances and also a level of external expertise and support.

22 It is important that service providers continue to meet the Quality Standards at all times, including during the course of infectious disease outbreaks. In doing so, service providers are expected to continue to provide quality care and a safe environment for their residents. Such an obligation should not be conflated with a requirement to provide what in normal circumstances should be hospital-level care and infection control. It would, in my view, be unreasonable to impose such an expectation on a residential aged care facility in light of:

(a) the functions and purpose of a residential aged care facility, which is first and foremost a home and not a health service (as discussed further below);

[2] I understand that these obligations are addressed in the statement of Glenys Ann Beauchamp dated 15 November 2019.

(b) the expectations of the community as to the type of services available at a residential aged facility;

(c) the significant distinction between the general operations of a residential aged care facility and a hospital, including the scale of each respective operation (as discussed further below);

(d) the intensive resources required to provide a hospital-like service and how this would compare to the average level of resources available to an operator of a residential aged care facility;

(e) the size and type of workforce required to provide acute care and how this would compare to the average composition of the workforce of a residential aged care facility. In particular, the difference between the clinically trained staff who are primarily responsible for care of patients in a hospital and the personal care workers who form the bulk of the aged care workforce;

(f) the need in normal circumstances for many residents to be transferred to and managed in hospital if their acute or declining clinical condition requires it; and

(g) the right and expectation of elderly people that they will continue as individuals to have access to acute care when it is indicated and desired whether or not they are in a residential aged care facility.

23 As noted above, and discussed further below in response to question 7, residential aged care facilities are first and foremost the home of the resident, and as such have a different environment, layout and furnishing (including personal possessions) when compared with a hospital. Activities related to daily life are part of the regular and core functioning of a residential aged care facility (unlike hospitals), with these facilities having to provide community access, entertainment, social engagement, maintenance of psychological wellbeing, and maintenance and support of independent functioning.

24 In hospital the main and core focus is on clinical care. The layout, infrastructure and available expertise supports clinical care. The design of hospitals has IPC at the fore. Accordingly, it is easy to move people from one area to another just by swapping beds. The systems are in place prior to any infected patient arriving in the hospital, and each bed area has oxygen, suction, space for equipment and an emergency call system. Staff are trained for the roles they perform and are used to working in a health care environment. In this environment, there is immediate and ongoing access to clinical assessment, medication, intravenous access and support, medical equipment, airway and defibrillation support, and a range of specialist advice and support. These things are not easily provided in a residential aged care facility, and even where available (on an “in-reach” basis) in a continuous and timely manner. Staff are also trained, monitored and supported to maintain effective IPC and PPE, and the bulk of the relevant workforce is clinically trained, unlike personal care workers. It is easier in this setting to transfer extra staff to support increased care needs as required.

25 The nature and design of the physical space is also different. Hospital spaces are easy to disinfect. In a COVID-19 setting in a hospital, care for infected in-patients is provided by trained staff working in clearly separate and fit-for-purpose zones. There is no intermingling with uninfected patients or the staff caring for them, as care of infectious patients is able to be separated completely from the general

patient and staff population, including where required, negative-pressure spaces. Clinical conditions managed in hospital are often acute, severe, life-threatening, distressing or complex and unstable requiring investigation such as blood tests and x-rays.

7)	In light of your experience responding to COVID-19, do you consider the standards and accompanying guidance that relate to infection control and clinical governance in approved providers are adequate? How could they be strengthened or clarified? Should there be a greater alignment with the National Safety and Quality Health Service Standards?

26 There are several requirements in the Quality Standards that go to a service provider's responsibilities in the area of infection control and clinical governance. These requirements, which primarily fall under Standard 3 (personal care and clinical care) and Standard 8 (clinical governance), are as follows:

(a) **Standard 3, Requirement 3(3)(g):** This covers the minimisation of infection-related risks through implementing standard and transmission-based precautions to prevent and control infections. In complying with this requirement, organisations are expected to:

(i) assess the risk of, and take steps to prevent, detect and control the spread of infections;

(ii) develop and implement an effective infection prevention and control program that is in line with national guidelines; and

(iii) offer workforce influenza vaccinations, keep records of these vaccinations and promote the benefits of the vaccinations.

In complying with this requirement, the ACQSC expects that as part of its infection control management, a service provider has clear guidelines on how and when to notify state/territory health departments of actual and suspected infectious outbreaks.

(b) **Standard 3**, **Requirement 3(3)(b)**: This requires effective management of high-impact or high-prevalence risks associated with the care of each consumer. As elderly people are most at risk of serious infection by COVID-19, services need to do all they can to manage the risks of COVID-19. This means using best practice guidance, decision-making tools and protocols, and applying measures to make sure the risk is as low as possible, while supporting a consumer's independence and self-determination to make their own choices. Effective management of risks needs to be underpinned by clinical governance systems for safety and quality, which involves reviewing how personal and clinical care is delivered to apply new practices, such as those related to managing the risks of COVID-19. For high-impact or high-prevalence risks related to the personal and clinical care of each consumer, the ACQSC expects providers to use documented risk assessments and care and services plans to reduce these risks.

(c) **Standard 8, Requirement 8(3)(d)**: This requires effective risk management systems and practices, including managing high-impact or high-prevalence risks associated with the care of consumers. Accordingly, service providers need to maintain systems and processes that effectively help identify and assess risks to the health, safety and well-being of consumers in all

circumstances, including during the course of the COVID-19 pandemic. For example, there are some consumers more at risk during an infectious disease outbreak because of their health status, chronic disease or capacity to follow personal hygiene or isolation recommendations. A provider needs to maintain a system to identify these consumers and manage the risks they face. It also includes identifying other risks to consumers posed by disruption to normal systems and processes during an outbreak.

(d) **Standard 8, Requirement 8(3)(e)**: This requires a service provider to maintain a clinical governance framework that includes oversight and implementation of infection control. This requirement goes to effective organisation wide systems required to prevent, manage and control infections. It requires a provider to have more than protocols in place, but to also ensure that they are actually being followed at all times. In accordance with this requirement, the governing body is held accountable for clinical quality and safety performance, as well as being responsible for setting the strategic direction for clinical quality and safety, understanding the risks associated with the quality and safety of clinical care, monitoring performance, detecting adverse events or new risks and driving improvement.

27 In my view, the Quality Standards identified above are adequate and fit for purpose as they contain clear principles and obligations that go towards the management of infectious disease outbreaks. As noted above, the Quality Standards also clearly outline that service providers are obligated to provide quality care and a safe environment for their residents in all circumstances. This includes through the provision of appropriate IPC and maintaining appropriate levels of clinical governance. The guidance material available to providers gives more detailed information on the Quality Standards and makes it clear how providers can meet these obligations. Clinical guidelines and best practice information are also available to service providers from a number of other sources including the Communicable Diseases Network of Australia and the Department of Health.

28 Notwithstanding the above, it is clear that the onset and impact of the COVID-19 global pandemic was unexpected and beyond what most aged care providers would have planned for when designing their physical layout, infection control protocols and clinical governance frameworks. It has become apparent that some aged care facilities could be better prepared for an outbreak in their service, noting that some were and are very well prepared. Advice on preparation has been developed and promulgated as information and experience continues to be gained. An outbreak in a service can have a wide range of consequences and it is a challenge for managers of these facilities to foresee all of the worst case scenarios. Accordingly, the pandemic has demonstrated the opportunity for further guidance material to be developed and made available to providers that can help guide them through issues encountered in this pandemic. In reflection of this, the ACQSC has released a number of resources, available on its website, in respect of the COVID-19 pandemic.

29 This is consistent with the ACQSC's usual approach to the provision of additional guidance on the Quality Standards. The ACQSC monitors requests for information and clarification, complaints and 'unmet' findings in relation to the Quality Standards. The ACQSC is able to respond to these matters through a range of different types of communication, including extra advice, guidance and resources

to strengthen the understanding in relation to the issue identified. As evidence changes or evolves, guidance is amended to reflect and communicate that. Guidance is also provided in a form that will be both read and understood. Given the diverse audience, operating in different roles in residential aged care facilities, guidance can be adapted for purpose. Developing, reviewing, and updating ACQSC guidance materials is dynamic and ongoing, and is often undertaken in consultation with clinicians.

Should there be a greater alignment with the National Safety and Quality Health Service Standards?

30 The National Safety and Quality Health Service Standards (**Health Standards**) are designed to be used in health services such as hospitals, not aged care services. They are written with an assumption of infrastructure and resources that are not always or immediately available to aged care services. However, best practice is just that, and where it is applicable and appropriate, the alignment should be clear.

31 For there to be greater alignment between the Health Standards and the Quality Standards, an exercise will need to be conducted as to how the requirements of the Health Standards could be adapted for aged care, and whether seeking this alignment would result in better quality care for residents of aged care services and patients receiving health services. For example, there is an opportunity, in my view, to review whether greater alignment could be achieved in respect of transition of care, where individuals are transferred between a residential aged care facility and a hospital. The mutual expectations, messaging and guidance for best practice should clearly align, and this could be expected to result in better outcomes.

32 In my view, there are many inherent differences between the provision of aged care (particularly residential aged care) and the provision of health services which may not allow full alignment in standards to be a desirable (or feasible) outcome. The differences are broadly in priority, expertise and focus. Most importantly, despite the complex chronic co-morbidities and frailty of many of the individuals who reside in residential aged care facilities, the residential aged care facility remains the *home* of those residents. These aged care facilities cannot be equated with facilities that are designed solely for the provision of health services, such as hospitals where average length of stay is less than five days. This factor also creates a need to balance any prescriptive health and clinical standards against an aged care consumer's independence and self-determination to make their own choices including crucially where it relates to goals, priorities and ongoing quality of life. These types of factors are not always as relevant in health services where the patient is managed for a short time, often with different expectations of the outcomes such as maintenance of independent function and quality of life versus management of an acute clinical problem.

33 Regard should also be had to the fact that the Health Standards are targeted to a more clinically trained and well-educated audience. As they only relate to the provision of health services, the Health Standards have a clinical focus and can also be quite prescriptive which limits flexibility in particular circumstances. Ultimately, the Health Standards are directed at components of care, whereas the Quality Standards are focused on the whole of a person's experience in aged care. These are core

aspects of the Health Standards which may not lend themselves towards full alignment with the Quality Standards.

34 For these reasons, rather than focus on alignment with the Health Standards, the priority should be to ensure that the guidance given to providers on the obligations contained in the Quality Standards is continuously improved to reflect changes in the environment and consumer expectations, and to reflect new evidence about best practice and outcomes specific to the aged care setting.[3] This includes highlighting best practice contained in the Health Standards wherever it is applicable and helpful in aged care. As a result, and as outlined above, there is clear opportunity for the ACQSC to develop better guidance for providers on how to deal with infectious disease outbreaks in future based on learnings continuing to unfold in this current pandemic.

8)	Provide any other reflections from a clinical perspective on lessons that can be learned from the response to COVID-19 in aged care to date.

35 Many lessons have been learned from the outbreaks in aged care (both residential and home care) that the ACQSC has been monitoring and involved with. While the pandemic is ongoing, my observations at the current stage (in addition to the views outlined above) are as follows:

(a) The approach of Public Health Unit structures and personnel has differed between jurisdictions and this inconsistency has caused some early challenges.

(b) Experience shows that outbreaks can be confined to a single staff member if detected early,[4] but can very quickly lead to an extensive outbreak once there are infected residents.

(c) Complexities and increased risks arise in the management of an outbreak where:

(i) there are shared rooms and shared bathrooms;

(ii) staff work across areas or in more than one facility;

(iii) residents have high care or memory and behaviour support needs;

(iv) there are a large number of residents sharing communal areas;

(v) the outbreak in a service is already widespread on initial detection; and/or

(vi) there are delays in:

(A) recognising and isolating new suspected cases;

(B) identifying close contacts, and isolating staff;

(C) instituting full PPE use;

[3] Noting that medical research often excludes very elderly, frail or cognitively impaired people from participation.

[4] Noting that this is not always possible due to asymptomatic presentations which create significant challenges in early detection. In this circumstance, constant vigilance (from staff and the facility) is key, with it being vital that the facility is prepared to respond rapidly if an infection occurs.

(D) developing separation strategies to protect those not infected or not yet testing positive;

(E) instituting widespread testing; and

(F) obtaining test results.

(d) The impact of the loss of normal staffing arrangements during the course of an outbreak is often underestimated, can be extreme and include reluctance and fear from staff resulting in worker refusal. Normal handover and clinical monitoring processes, medication management, risk awareness and the detection of clinical deterioration can all be impacted from the use of staff unfamiliar with the service and the individual residents.

(e) The complexity of the residential aged care setting is under-recognised in terms of the contribution of numerous interactions, centralised systems such as food preparation and delivery, and infectious spaces and surfaces, which may make normal contact tracing insufficient.

(f) There are significant challenges posed by the emerging evidence of infection transmission by asymptomatic individuals in a high density environment.

(g) A cautious approach involving widespread early testing of residents and staff, and frequent ongoing testing where required, has at times detected the early spread of COVID-19 within a facility and has assisted with management of the outbreak.

(h) Once there is an outbreak within a facility, the risks to staff of having become or becoming infected during the course of their work is relatively high, especially before or when the outbreak is first identified in the facility.

(i) The logistical difficulty in protecting negative residents by internal cohorting can be either overcome quite easily or be prohibitive depending on individual service characteristics.

(j) Management of an outbreak in a facility is most straightforward and works best for the interests of vulnerable elderly residents if all stakeholders engage in a collaborative and flexible way on a case by case basis to ensure that the wellbeing and safety of all residents is optimised.

(k) There is no 'one size fits all' approach to managing outbreaks in residential aged care services. The approach to protection from infection and access to clinical care for residents needs to be tailored to their individual circumstances.

Signature	Melanie Wroth	Witness	E. Huntly
Name	MELANIE WROTH	Name	ELIZABETH HUNTLY
Date	27/7/20	Date	27/7/20