Aged Care Royal Commission

UnitingCare Australia response to investigation of the impacts of the COVID-19 pandemic on aged care services

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About UnitingCare Australia

UnitingCare Australia is the national body for the Uniting Church's community services network and is an agency of the Assembly of the Uniting Church in Australia.

We give voice to the Uniting Church's commitment to social justice through advocacy and by strengthening community service provision.

We are the largest network of social service providers in Australia, supporting 1.4 million people every year across urban, rural and remote communities.

We focus on articulating and meeting the needs of people at all stages of life and those that are most vulnerable.

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Introduction

UnitingCare Australia welcomes the invitation from the Royal Commission to make submissions to enable an investigation of the impacts of the COVID-19 pandemic on aged care services.

Residential aged care services have served the country well in terms of preparing for the pandemic, and managing at a local level. The difficulty in containment of the infection has been observed at one site: sadly with considerable public airing of negative *opinions* about how well the staff and management have responded. Unfortunately this sits alongside minimal recognition of the outstanding work done by aged care providers and their staff to prepare for and mitigate the risk of the pandemic entering the aged care setting. Older people in other countries have been less fortunate, and we hope that governments will compare and contrast the low number of deaths in Australia with the high level of deaths in residential care settings in some countries, such as the UK, Canada and the United States

This submission deals with a single issue, that of the way in which health and aged care systems are currently positioned in the context of potential outbreaks in residential aged care facilities. We believe it is important that current guidelines be adjusted, to reflect the rights of older people living in residential care facilities to equal access to health care as any other individual in the community. It is important that we make this change now. The pandemic is ongoing and we must initiate the process of learning immediately, in order to best mitigate the current risks presented by the virus.

In this submission we will focus on the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities (RCF) in Australia (**https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-outbreaks-in-residential-care-facilities**) and where relevant other resources available to aged care providers by the Commonwealth Department of Health.

UnitingCare Australia intends to make a further submission to explore the broader range of issues and impacts that have arisen due to the COVID-19 pandemic.

Context

In her evidence to the Royal Commissioner in February Ms Claerwen Little, National Director of UnitingCare Australia identified some key needs and expectations of the community that the aged care system must meet. The following are particularly relevant to this investigation.

a. That as they age, people are treated with care and compassion and that their rights and dignity are respected.

b. That consumers have a meaningful choice about the aged care they will receive.
…

e. That aged care is provided by a skilled and adequate workforce, paid at levels comparable with similar positions in other sectors.

f. That visits to hospital be made only when necessary and not compromise a person's health.
…

h. That Government and providers develop a broader range of models and systems of health delivery to prepare for a changing future.

In the first phase of the pandemic (roughly January–April) the initial response from services was to direct their resources towards responses that would minimise community transmission to older people (both those in the community and residing in aged care facilities) and preparing facilities to be able to contain cases in facilities if they were to occur. In other words, aged care providers considered their responses a critical element of public health strategies to 'flatten the curve'.

The Communicable Diseases Network Australia (CDNA) National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (the CDNA guidelines) developed in March 2020 and revised in April assumed:

> A COVID-19 pandemic will affect the entire health care system and the community. Hospitals, local public health units and other services may have limited capacity. RCF may not be able to rely on the same level of support they receive now from other parts of the health care system or from other community services during an outbreak.
>
> …
>
> The number of health care workers available to provide care may be reduced by up to one-third because of personal illness, requirements to self-quarantine, concerns about transmission in the workplace, and family/caregiving responsibilities.
>
> Usual sources of supplies are disrupted or unavailable.
>
> Care protocols may change and new practice may have to be adapted…

Effectively, the guidelines assumed a scenario in which – as has been the case in many overseas countries – the health system was overwhelmed to the extent that it may be necessary to accept a situation in which not every individual who contracted COVID-19 could receive the highest level of medical intervention. (More detailed assumptions were set out in the Australian Health Sector

Emergency Response Plan for Novel Coronavirus (COVID-19), which underpins the requirements of the CDNA guidelines.)

Australia has been fortunate the 'first wave' has been contained and the community is able to move from the initial phase of the national response plan to the second. This assumes a level of community transmission that is manageable for the public health system. **In this context, we consider that, where the advice of the individual's primary physician or other relevant clinical specialist, including infection control specialists, is that they are better off if they are transferred to hospital rather than remaining in the facility, the right to do so on the same terms as any other individual in the community should be guaranteed.**

UnitingCare Australia makes this submission in the belief that governments must revise the CDNA guidelines as their application in the current situation potentially represents an abrogation of their responsibility to provide the best and safest options for the care of older people in our society. The guidelines reflect a tolerance for risk in residential aged care facilities that is not appropriate in current circumstances.

Ambiguity in the March/April 2020 CDNA guidelines

The section on Roles and Responsibilities (p2) reflects that the primary responsibility of managing COVID-19 outbreaks lies with residential care facilities (RCF), within their responsibilities for resident care and infection control. All RCF should have in-house (or access to) infection control expertise, and outbreak management plans in place.

Further, RCF are required to:

- Detect and notify outbreaks to state health departments.
- Self-manage outbreaks in accordance with this guideline, the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019), and the Australian Health Sector Emergency Response Plan for Novel Coronavirus (2020).
- Confirm and declare an outbreak (refer to section 5).
- Follow advice on infection control measures and appropriate use of PPE, available on the Department of Health website.
- Confirm and declare when an outbreak is over (refer to section 5).

This statement reflects that the legal and ethical risks of decisions relating to the safety and care of individuals who receive aged care services are primarily borne by aged care providers.

The element of the guidelines that is proving problematic for members of the UnitingCare network relates to transfer to a public hospital, or in other words, the interface between the health and aged care sectors in the case of an outbreak.

The section of the guidelines on Response to a Suspected Case of COVID-19 in a Resident (p14) states that residents with suspected or confirmed COVID-19 require appropriate healthcare support...

> Special considerations in the management of residents with suspected or confirmed COVID-19 in an RCF include:
>
> - Immediately isolate ill residents and minimise interaction with other residents.
> - If COVID-19 is suspected, have a low threshold for requesting medical review and testing.
> - Transfer residents to hospital ***only if their condition warrants***. …
>
> In the instance of confirmed COVID-19, RCF management should consider this an opportunity to:
>
> - Identify and implement enhanced infection control measures
> - Implement surveillance for further cases
> - Review outbreak plans and requirements for implementation.

The bold, italicised caveat in this statement, taken together with Departmental information about expectations of the level of preparedness that facilities should adopt (for example see **https://publish.viostream.com/app/s-n411ghp**) and communications from some jurisdictions regarding transfers, have created a situation where providers anticipate that transfers at the request of facilities could be refused.

In the absence of unspecified clinical indications[1], this would leave facilities with only the option of 'isolation and cohorting' (as described in the CDNA guidelines, p16) to prevent transmission of COVID-19 from these individuals to others in the facility:

> RCF should refer to the ICEG IPC guideline for detailed information on the placement of residents within the RCF. A resident with an ARI should be placed in a single room with their own ensuite facilities, if possible, while a diagnosis is sought. Where possible, residents requiring droplet precautions should be restricted to their room. Residents may attend urgent medical or procedural appointments but should wear a mask if tolerated.
>
> Once resident isolation or cohorting measures are in place, to further reduce the risk of transmission, it is preferable to allocate specific RCF staff to the care of residents in isolation (i.e. staff cohorting). The RCF should ensure there are sufficient RNs at the facility to allow this, which may require surge staffing. A register of staff members caring for patients with COVID-19 should be maintained by the RCF. The RCF must ensure that staff members:
>
> - do not move between their allocated room/ section and other areas of the facility, or care for other residents
> - self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell.
> - do not work in other facilities even if asymptomatic.

[1] The WHO Operational considerations for case management of COVID-19 in health facility and community, **https://www.who.int/publications-detail/operational-considerations-for-case-management-of-covid-19-in-health-facility-and-community** [accessed 25/5/20] recommendations based on case severity and risk factors do not include a classification of 'mild with no risk factors', suggesting that any person over 60 (or with other risk factors) should be instructed to self-isolate and call COVID-19 hotline for emergency referral as soon as possible, followed by hospitalization for isolation (or cohorting) and inpatient treatment. Known risk factors for severe COVID-19 include: age over 60 years, hypertension, diabetes, cardiovascular disease, chronic respiratory disease, immunocompromising conditions.

We note that the Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities advice dated 16 May 2020 is in contrast with the guidelines in the degree of prescription and better reflect the role of RCFs in decision making i.e. that transfer to hospital 'should be considered for residents whose condition warrants it, in consultation with relatives and taking into account their previous health status and advanced care directive'.

We believe this is nevertheless too narrow, in that it fails to take into account the broader set of responsibilities and risks borne by a facility. When an outbreak occurs, a facility is responsible for determining the course of action that best serves not only the interests and safety of the individual, but also the interests and safety of other individuals in the facility, as well as the staff and essential visitors to the facility.

In fact the CDNA guidelines contain the caveat that

> [r]eaders should not rely solely on the information contained within this guideline. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, advice from a health professional. Clinical judgement and discretion may be required in the interpretation and application of these guidelines.
>
> The membership of CDNA and AHPPC, and the Commonwealth of Australia as represented by the Department of Health (the department), do not warrant or represent that the information contained in the guideline is accurate, current or complete. CDNA, AHPPC and the department do not accept any legal liability or responsibility for any loss, damages, costs or expenses incurred by the use of, reliance on, or interpretation of, the information contained in the guideline.

The impacts of this ambiguity on outbreak planning

UnitingCare Australia has been fortunate to avoid any outbreaks of COVID-19 in their facilities. Organisations within our network have been committed to avoiding outbreaks in facilities, while applying the learning from overseas experiences to outbreak response planning. Key pieces of evidence from overseas indicate that

- strategies should assume that, in the event of an outbreak, significant numbers of aged care workers will become unavailable to work, due either to infection or choosing to self-isolate to protect their own or their families' health
- once an outbreak is experienced in a facility, it is very difficult to contain, due to factors including the availability of and capacity of staff to use PPE as necessary, presenteeism due to financial dependence on work etc.)

Anecdotally, this situation has been exacerbated in many countries by a lack of integration between hospital and 'social care' facilities, with hospitals in the UK, for example, initially refusing to accept transfers of COVID-positive individuals and taking inadequate precautions, leading to transfer of COVID-positive individuals into the residential aged care system.

UnitingCare Australia believes that taking into consideration

- current resources and access to staff
- the purpose for which aged care residential facilities are designed and accredited (as homes and not acute care facilities), and
- the increasing volume of expert advice that if there is an outbreak the spread of COVID-19 is unlikely to be contained by standard infection control measures as practised in residential care facilities

none of our services would be confident that an outbreak of COVID-19 could be contained with an infected resident on site.

UnitingCare Australia therefore believes that a key assumption in the guidelines—and a key element in public health preparedness and planning—should be that a person in a high risk category, suspected or confirmed to have contracted COVID-19, will need to be automatically transferred to hospital. Rather than assuming that an individual can be effectively quarantined within a facility**, it should be assumed that an individual cannot be effectively quarantined or receive appropriate clinical care within a facility.**

We consider it is critical that when a facility considers their capacity to implement appropriate quarantine and cohorting measures, alongside other factors relevant to the care of an individual who has tested positive, they can take a precautionary approach knowing that the *option* to send an individual to hospital for their own and others' benefit is available.

Without assurance that this is an option, it is not possible for a facility to manage the risks associated with having a COVID-19 positive resident on-site.

Based on what our members know of the way in which various parties responded to the Newmarch outbreak, they are concerned that a local health authority may enforce a 'hospital in the home' approach to treatment of individuals with COVID-19, regardless of the capacity– at that point in time – of the individual facility to provide appropriate care, quarantining of that individual and cohorting, while simultaneously providing ongoing care necessary for the safety of the broader residential community. We do not believe that it is reasonable, under current financial and workforce circumstances, for every facility to operate at the capacity that would be necessary to contain an outbreak, as a standard precautionary measure.

We recommend that:

1. the CDNA guidelines should be revised immediately to remove inferences that residents of an aged care facility would have a lesser right to access hospital services or be safely quarantined than other individuals in the community, including the ambiguous point 'Transfer residents to hospital **only if their condition** warrants'
2. the CDNA guidelines must be consistent with a residential facility operator's obligations to consider all of the relevant circumstances when making the judgment that a resident should be transferred immediately to an appropriate acute health facility;
    a) providers should, as part of their outbreak planning processes, be required to consult with their local communicable disease authorities to establish which acute health facility is the most appropriate to care for a transferee, noting that it might not be the closest facility;
    b) state and territory governments should develop an evidence-based process for assessing whether quarantining and cohorting can be safely managed at a particular facility;
3. at least for the duration of the pandemic situation
    a) a specialist geriatrician/member of the Australian and New Zealand Society for Geriatric Medicine (ANZSGM) with relevant practical experience should be appointed to the Infection Control Expert Group
    b) a representative of the aged care sector should be appointed as an observer to the Infection Control Expert Group
    c) government must continue financial assistance proportionate to the additional cost of implementing risk mitigation options
    d) government must continue to build staffing capacity to ensure that providers have optimum choice in mitigating risk, for example by enhancing the numbers or levels of qualification for staff, or having the capacity for staff to be accommodated on-site in the event of local outbreaks.