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Royal Commission into Aged Care Quality and Safety: Impact of COVID-19 on Aged Care Services June 2020

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to respond to the Royal Commission into Aged Care Quality and Safety's call for submissions about the impact of the coronavirus (COVID-19) on the aged care sector. This submission is a supplementary document to the response previously provided by ACEM to the Royal Commission in September 2019, intended to provide comment specific to the context of the COVID-19 pandemic.

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED). It is ACEM's position that all older people should be able to access timely, responsive, affordable and appropriate health care, particularly acute healthcare[1]. Such care should be person-centric, be of a high standard and where feasible, delivered in the environment of their choice (whether it be their own home, emergency department or residential aged care facility).

Overview

Both globally and within Australia, the disproportionately high fatality rates amongst older persons during the COVID-19 pandemic has highlighted the unique and complex factors faced by this group in the face of life-threatening pandemics. Of the 102 total COVID-19 deaths recorded in Australia as of 22 June, 29 of these were people living in Australian Government-subsidised residential aged care facilities and 3 were people receiving Australian Government-subsidised care in their own home.[2]

Older persons living in Residential Aged Care Facilities (RACFs) are one of the most vulnerable groups as once a case is present in a facility, the high density living and extensive close physical contact between staff and residents makes it is extremely difficult to prevent further transmission and outbreak.[3] Recent outbreaks in RACFs in Australia have demonstrated significant gaps in pandemic planning and infection control, issues that have been aggravated by the widespread understaffing, under-resourcing and lack of clear governance in the aged care sector already acknowledged by the Royal Commission prior to the COVID-19 pandemic. Furthermore, the emergence of COVID-19 has raised important ethical issues about the healthcare rights of older persons, with often concerning social discourse and media portrayal contributing to ageism, discrimination and stigma.[4]

[1] Australasian College for Emergency Medicine. Care of older persons in the emergency department. Melbourne: ACEM; 2020. Available from: https://acem.org.au/getmedia/bfd84f83-fcb2-492a-9e66-47b7896e5c70/P51_Care_Elderly_Patients_in_ED_Sep-15.aspx

[2] Department of Health. Coronavirus (COVID-19) current situation and case numbers. Australian Government [cited 2020 18 June]. Available from: 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

[3] Communicable Diseases Network Australia (CDNA). Coronavirus disease 2019 (COVID-10) outbreaks in residential care facilities. Canberra: CDNA; 2020.

[4] United Nations (UN). Policy brief: the impact of COVID-19 on older persons. Geneva: UN; 2020. Available from: https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf

ACEM recognises that the Australian Government has provided considerable assistance to the aged care sector during the COVID-19 pandemic, however we believe that improvements are needed to better protect older Australians and aged care employees from future pandemics or infectious disease outbreaks. Emergency departments (EDs) and hospitals are often perceived as a safe and secure environment, however the vulnerability of older persons and complexities of the COVID-19 pandemic have created numerous challenges for emergency physicians and have increased the risk of these settings for frail older persons, regardless of whether they are a suspected or confirmed COVID-19 case. A summary of key issues is outlined below, with our observations relating not only to pandemic-specific matters but also extending to systemic issues in Australia's aged care and health system and wider entrenched ageism.

1. Pandemic planning and governance of residential aged care facilities (RACFs)

As previously acknowledged by the Royal Commission, the aged care system is complex and fragmented. Even though funding and regulation is provided by the Commonwealth, there are blurred roles and responsibilities for local and state governments.[5] This diffusion of responsibilities and complex governance arrangements contributed to increased harm for RACF residents during COVID-19 as planning and action was delayed due to confusion about where responsibility lay. It is very difficult for agencies across the health system to work together to plan and coordinate outbreak response and management when role responsibilities are unclear, further complicated by inconsistent guidance from state and national governments due to each jurisdiction applying different restrictions and guidelines. As discussed in our previous submission, clarity of whether RACFs are considered part of the health care system is important.

Previous studies of RACFs in Australia have found large variations in the quality of outbreak prevention and preparedness measures, with the view that accreditation standards for communicable disease control are inadequate and it is difficult for staff to comply with infection control and outbreak prevention recommendations due to the high level of personal contact involved in aged care activities.[6,7] These issues have been brought to the fore during the COVID-19 pandemic, with a survey conducted by the Australian Nursing & Midwifery Federation during April and May finding that only 40% of respondents believed their facility was adequately prepared for a COVID-19 outbreak and more than three-quarters (77%) reported working in facilities that had only recently updated or implemented infection control measures for staff.[8]

The emergence of COVID-19 clusters in RACFs demonstrates the critical need for RACFs to have detailed outbreak prevention and management plans, as well as clarity of responsibilities and relationships with state and federal health authorities for surveillance and monitoring, rather than waiting to jump to action once an outbreak has already begun and being unclear about who is the responsible authority to seek leadership from. The COVID-19 situation has been extremely challenging for RACFs and staff in these facilities have done an incredible job to continue to provide care to residents during this time, however the current blurred responsibilities and governance arrangements have left them without clear leadership and placed immense pressure on a sector already subjected to immense criticism.

2. Personal Protective Equipment (PPE)

The emergence of cluster outbreaks of COVID-19 in RACFs has demonstrated the immense resourcing necessary to keep staff and residents safe, including masks, gowns, eye protection and gloves cleaning and sanitation products and implementation of social distancing measures and visitation policies. Close personal contact between staff and residents occurs on multiple occasions during the day in RACFs so this presents huge requirements for PPE supplies. RACFs must wait for a confirmed case of COVID-19 before accessing the national stockpile so insufficient levels of PPE were available for staff and residents to prevent spread during early outbreak stages. The need for adequate, timely access to PPE is further highlighted by the high rates of asymptomatic or pre-symptomatic COVID-19 cases in previously documented RACF outbreaks.[9]

[5] Smith C. Navigating the maze: an overview of Australia's current aged care system. Background paper 1. Royal Commission into Aged Care Quality and Safety: Canberra; 2019. Available from: https://agedcare.royalcommission.gov.au/publications/Documents/background-paper-1.pdf

[6] Latta R, Massey, P, Merritt T, Eastwood K, Islam F, Durrheim D. Outbreak management in residential aged care facilities – prevention and response strategies in regional Australia. Aust J Adv Nursing. 2018;35(3):6-13.

[7] Huhtinen E, Quinn E, Hess I, Najjar Z, Gupta L. Understanding barriers to effective management of influenza outbreaks by residential aged care facilities. Australas J Ageing. 2018;38(1):60-63.

[8] Australian Nursing & Midwifery Federation (ANMF). Aged care COVID-19 survey: preliminary report. ANMF; 2020. Available from: http://www.anmf.org.au/documents/reports/ANMFAgedCareCOVID-19Survey2020_PreliminaryReport.pdf

[9] Kimball et al. Asymptomatic and presymptomatic SARS-CoV-2 infections in residents of a long-term care skilled nursing facility. MMWR. 2020;69(13):377-381.

Furthermore, aged care staff were not properly trained in the use of PPE before the pandemic and considering that experienced hospital staff often find it difficult to wear this equipment, it is unsurprising that there have suggestions of possible breaches of PPE protocol in facilities where outbreaks have occurred.[10] Infection control breaches in outbreaks have been potentiated by the isolation of usual staff and replacement by agency staff often not familiar with the RACF environment or complex care needs of residents. There is an inherent tension between the appropriate availability of PPE and providing quality of care to residents during an outbreak, so it is imperative that system wide improvements are made to mandate PPE training for all RACF staff and guarantee appropriate supply levels for all facilities.

3. RACF Staffing

Extremely trying circumstances and time and resource constraints were conveyed by many former and current aged care staff to the Royal Commission during 2019.[11] This pandemic has placed further pressure on the industry and aged care workers are reporting "significant levels of stress, pressure and a lack of support as the sector grapples to combat COVID-19". Understaffing has already been highlighted as a problem in RACFs, yet despite many staff being willing to work more shifts to assist during the pandemic, staffing levels have not increased, and in some cases the workforce has actually reduced.[12] These workforce reductions may been due to the logistics associated with managing outbreaks and complying with social distancing and quarantine regulations, however alternate arrangements were not put in place to ensure appropriate staff levels to maintain required standards of patient care. A review of minimum staffing levels and workforce capacity building will be an essential part of preventing the further spread of COVID-19 in these facilities.

4. Hospital transfer, admission and discharge of RACF residents

As outlined in ACEM's original submission to the Royal Commission, 13-40% of transfers of RACF residents to EDs are potentially avoidable through the provision of quality clinical care in facilities. Avoiding unnecessary transfer is important as hospitalising RACF residents places them at risk of further deterioration and is associated with high rates of delirium, falls, pressure sores, nosocomial infections and medication errors.[13] During COVID-19, ACEM's members, working in emergency departments across Australia and New Zealand, have been strongly aware of the need to give special consideration to vulnerable groups such as older persons and sought to avoid unnecessary hospital transfer of RACF residents. The College has developed older person-specific recommendations as part of the Clinical Guidelines for the management of COVID-19 in Australasian emergency departments and we strongly support the guidance provided by the Communicable Diseases Network Australia (CDNA) for transfers to and from RACFs where a COVID-19 outbreak is suspected or confirmed. Further actions recommended by ACEM to help prevent unnecessary hospital admissions and provide safe transfer, admission and discharge if necessary, include:

- Disaster plans to incorporate cross-sector support for RACFs and General Practitioners (GPs)
- Community-based forward triage of RACF residents (with COVID-19 and with non-COVID-19 presentations) to minimise harm to residents and achieve sustainability of acute health service delivery. Decisions to transfer RACF residents to hospital should include assessment of:
    - Advance care planning and goals of care
    - Frailty and comorbid illness
    - Risks of transfer and potential benefits
    - RACF capability and capacity to attend to care needs
    - Public health imperatives
    - This may be supported by telehealth/telephone triage assessment utilising RACF support services e.g. Queensland Health's RACF acute care support services (RaSS) and CARE-PACT
- All hospital jurisdictions implement or expand geriatrician, palliative care and emergency physician-led telehealth services to support RACFs and GPs
- RACFs and GPs, with health service support where necessary, immediately prioritise advance care planning with residents and their health decision makers

[10] Newmarch House death toll rises to 16 as worker stood down amid alleged infection control breach. The Sydney Morning Herald. 2020 May 5 [cited 2020 June 18]. Available from: https://www.smh.com.au/national/aged-care-worker-stood-down-from-newmarch-house-amid-allegations-of-infection-control-breach-20200505-p54pwj.html

[11] Royal Commission into Aged Care Quality and Safety. Interim Report: neglect. Canberra: Commonwealth of Australia; 2019

[12] Australian Nursing & Midwifery Federation (ANMF). Aged care COVID-19 survey: preliminary report. ANMF; 2020. Available from: http://www.anmf.org.au/documents/reports/ANMFAgedCareCOVID-19Survey2020_PreliminaryReport.pdf

[13] Australasian College for Emergency Medicine. Care of older persons in the emergency department. Melbourne: ACEM; 2020. Available from: https://acem.org.au/getmedia/bfd84f83-fcb2-492a-9e66-47b7896e5c70/P51_Care_Elderly_Patients_in_ED_Sep-15.aspx

- RACFs and GPs proactively change residents on nebulisers to metred aerosols with spacers where clinically appropriate.
- Improved access of GPs and RACFs to telehealth support and hospital-delivered clinical support in the RACF environment, 24 hours per day.

It has been positive to see increased levels of ED outreach in some geographic locations e.g. Queensland Health's RACF acute care support services (RaSS), and the College notes that the temporary expansion of MBS telehealth services has helped increase options for care and reduced unnecessary hospitalisations from RACFs over the past few months. We support the expansion of these arrangements beyond the COVID-19 pandemic to support and enhance collaborative models of care and clinical decision-making between RACFs, GPs, hospitals and EDs.

5. Ageism, discrimination and stigma

In our original submission to the Royal Commission, ACEM raised concerns that cultural biases about the rights of older persons to healthcare may compromise quality of care and equitable access to appropriate treatment for this group. COVID-19 has raised ethical issues about the correct prioritisation for the allocation of scarce resources and unfortunately, we have witnessed ageism underpinning discussions about excluding older persons from care and limited consideration of solutions other than abandoning residents in RACFs. Media coverage has reinforced this stigma, not been patient-centred and has disregarded the equal rights of every older person. ACEM is concerned that these portrayals of older persons promote discriminatory attitudes that this sector of society does not matter and can be excluded from care. Should the pandemic worsen, this ageist and stigmatising discourse will disadvantage all groups that face bias, creating a shameful situation in Australia where only privileged groups will be able to gain help. ACEM does not support limitations on treatment based solely on age and believes that ethical decision-making frameworks are essential to ensure that older Australians, including residents of RACFs, are treated with dignity and respect.

Thank you for the opportunity to provide further comment to this Royal Commission. If you have any questions or require further information, please do not hesitate to contact ACEM via policy@acem.org.au.

Yours faithfully

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