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AMA submission to the Royal Commission into Aged Care Quality and Safety on the impact of COVID-19 on aged care services

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The AMA thanks the Royal Commission into Aged Care Quality and Safety (Royal Commission) for the opportunity to provide a submission into the COVID-19 response by the aged care sector. The AMA has been closely monitoring the developments in the aged care space throughout the COVID-19 pandemic. AMA members, many of whom care for patients in aged care, have previously expressed their concerns around the provision of aged care services to their older patients and identified areas for improvement. Their concerns inform AMA advocacy. The AMA submits that some of these improvements could have ensured that the pandemic was better prevented and managed in residential aged care facilities (RACFs).

The AMA has previously provided several comprehensive submissions to the Royal Commission, as well as multiple witness statements by the AMA President at the time:

- AMA Submission to the Royal Commission into Aged Care Quality and Safety dated 30 September 2019[1],
- AMA submission to the Royal Commission into Aged Care Quality and Safety in response to the Consultation Paper 1 - Aged Care Program Redesign: Services for the Future[2] dated 29 January 2020**,**
- Two witness statements of Dr Anthony Bartone, both dated 18 February 2019[3,4],
- Supplementary witness statement of Dr Anthony Bartone dated 27 November 2019[5], and
- AMA submission to the Royal Commission into Aged Care Quality and Safety – Required training for doctors working in aged care.

[1] Australian Medical Association (2019) AMA Submission to the Royal Commission into Aged Care Quality and Safety
[2] Australian Medical Association (2019) AMA submission to the Royal Commission into Aged Care Quality and Safety in response to the Consultation Paper 1 - Aged Care Program Redesign: Services for the Future
[3] Royal Commission into Aged Care Quality and Safety (2019) Statement of Dr Anthony Bartone
[4] Royal Commission into Aged Care Quality and Safety (2019) Additional Statement Dr Anthony Bartone
[5] Royal Commission into Aged Care Quality and Safety (2019) Supplementary Witness Statement Dr Tony Bartone

In addition, AMA President Dr Tony Bartone participated in a Royal Commission panel about the redesign of aged care services on 3 February 2020 in Canberra.

The AMA believes that health and aged care are two parts of the same system and this system should be better geared towards optimising the health and wellbeing of older and more vulnerable members of the Australian community. This submission addresses what the AMA sees as the shortcomings of the current aged care system and discusses their impact during the COVID-19 pandemic. This submission draws on previous submissions and statements made by the AMA and its President.

The AMA acknowledges that the COVID-19 pandemic is still ongoing and that new cases of infections in RACFs are still occurring. It may therefore be too early to assess the success of Government actions in aged care, as well as the success of the actions of other stakeholders. There may also be new information or new concerns that come to light.

The role of General Practitioners (GPs) and other medical practitioners

In its two previous submissions, the AMA noted that people are entering aged care older, frailer and with multiple co-morbidities. Therefore, the AMA believes the provision of adequate health and medical care in aged care settings should be at the forefront of any aged care system reform and redesign. In that context the AMA recommended that:

> *Recommendation 1: Retaining and increasing the number of doctors interested in working in the aged care space should be the focus of any future reforms in aged care if appropriate clinical care is to be provided. Investing in primary care for patients in aged care settings will save on public hospital expenditures.*

This includes non-GP medical specialists, especially geriatric medicine specialists and psychiatrists supporting the provision of GP care. In the AMA view COVID-19 will inevitably have mental health impacts on RACF residents, their carers, medical practitioners and other ancillary staff due to increased anxiety regarding health, isolation from family and the constant stream of negative media exposure. GPs will always be the first point of medical practitioner support for residents and their families, but this support should be complemented by access to psychiatrists and psychologists.

In its submission to the Royal Commission in September 2019, the AMA also maintained that future funding models for the health and aged care of older people need to recognise the important leadership role that GPs can play in providing advice on how to improve overall health outcomes beyond direct clinical needs. The AMA contended that GP-led teams can advise on policy procedures, clinical governance, and an appropriately resourced care environment. The AMA has also previously noted that GPs can and should be members of clinical governance teams in RACFs, ensuring that appropriate clinical care procedures are established and followed and that governing bodies maintain a clinical focus.

Throughout the pandemic the AMA has received updates from members, primarily GPs who work in the aged care space. Many AMA members expressed frustration with how some aged care providers were not well prepared and how they were handling the situation. Some AMA members raised concerns about some RACFs refusing to implement cohorting rules, claiming that residents cannot be isolated/moved due to security of tenure arrangements. The AMA asked for clarification from the Aged Care Quality and Safety Commission (the Commission) in March, early in the pandemic. However, during a webinar organised by the Department of Health on 8 May 2020[6], almost two months after the AMA enquiry, webinar participants, many of whom work in RACFs, were still asking for guidance around cohorting.

AMA members welcomed the guidance provided by the Department around management and prevention of COVID-19 outbreaks in RACFs[7,8,9] published in early March, but they also expressed some concerns. In a letter sent to the Department of Health and the Aged Care Quality and Safety Commission on 30 April, AMA GP members recommended that the government should consider amending cohorting guidance to allow for entirely separate RACFs where COVID-19 patients would be isolated and treated, preventing transmission inside a RACF. In their view, trying to isolate a positive case in situ is not feasible and the best way to contain the transmission is to isolate all infected residents in a separate area with separate staff, separate meals, and equipment. The AMA appreciates that this approach would require further consideration by Government experts and epidemiologists, as there are other factors to be taken into consideration when working with vulnerable RACF residents. Many RACFs have large numbers of residents with dementia, whose needs must be considered, including the need to minimise distress and ensure they are accommodated in dementia friendly environments. This is particularly important as hospitals are usually not suitable settings for people living with dementia[10,11,12].

AMA members were also frustrated that different jurisdictions were applying different rules and queried the guidance from health departments that RACF residents should be tested only if two or more residents show symptoms[13]. GPs looking after patients in RACFs have advised that they were frustrated at not being able to test individual residents suspected of having COVID-19 and were concerned by the potentially disastrous consequences of a failure to diagnose. The AMA is

[6] Australian Government, Department of Health (2020) Residential Aged Care COVID-19 Webinar
[7] Australian Government, Department of Health (2020) Corona Virus COVID-19 Outbreak Management in Residential Aged Care Facilities
[8] Australian Government, Department of Health (2020), COVID-19 Guidelines for Outbreaks in Residential Care Facilities
[9] Australian Government, Department of Health (2020), COVID-19 Guidelines for Infection Prevention and Control for Residential Care Facilities
[10] Hung et al (2016), Exploring the perspectives of patients with dementia about the hospital environment, International Journal of Older People Nursing, DOI: 10.1111/opn.12153 Page 2
[11] Bray et al (2015), Improving the hospital environment for people with dementia, Nursing Older People. doi: 10.7748/nop.27.9.16.s17
[12] Kurrle SE (2006), Improving acute care services for older people, Medical Journal of Australia 184, 427–428.
[13] See for example this Public Health Alert issued by the Queensland Government on 25 March 2019 that indicates that testing should occur in RACFs if there are two or more cases of illness clinically consistent with COVID-19, or this Advice from Tasmanian Government from 2 April 2020 advising that testing should only occur if there are two or more cases clinically compatible with COVID-19 in a residential care setting.

aware of a case of a patient with cough and fever symptoms residing in a RACF in Tasmania, where a request by their regular GP for COVID-19 testing was rejected by TAS Public Health. The reason given was that the patient was the only symptomatic resident at the RACF at the time. It was later revealed that the patient had been visited by a relative who had recently returned from overseas. The patient responded well to empirical treatment for pneumonia, but the GP was still concerned that they may have had COVID-19, and decided to test the patient through a private laboratory. Luckily, the test returned negative.

Further details on the letter to the Department of Health and the Aged Care Quality and Safety Commission can be found in *The role of Government and regulatory bodies* section of this submission.

Telehealth for RACF residents

While the focus of this submission is on aged care, the data shows that medical practitioners are also vulnerable to infection from COVID-19. The death tolls among health professionals in Italy, China and Spain have been high[14]. According to the Health Workforce Data 2018 statistics, the average age of a practising GP in Australia was 51.1 years[15]. Given that risk increases with age[16], this adds a further challenge to the already stretched health profession.

The AMA played a role in brokering the breakthrough agreement with the Federal Government for expanded telehealth access to GPs and other medical specialists that allowed for continuation of normal patient care and reduced the need for scarce Personal Protective Equipment (PPE). In the first submission to the Royal Commission in September 2019, the AMA argued for GP telehealth services to be expanded to cover services doctors are already providing to patients in RACFs. The AMA recommended to:

> *Recommendation 4: Introduce an MBS telehealth item for phone calls between the GP, RACF staff and relatives. This may reduce some barriers to accessing medical services after hours. The Government should consider introducing telehealth for RACFs for afterhours consultations as a pilot. Outcomes of such a pilot program will help inform government policy and provide an evidence base for informed decision making.*

According to the Health Minister, by 20 April over 4.3 million health and medical services were delivered to over 3 million patients through the new telehealth items[17]. The AMA advocates that RACF telehealth should be enabled on an ongoing basis.
Based on the lessons learned from the pandemic, the AMA would now expand the above recommendation to include non-GP specialists, such as psychiatrists and geriatric medicine

[14] I Yoshida, T Tanimoto, N Schiever, F Patelli, M Kami (2020), Characteristics of doctors' fatality due to COVID-19 in Western Europe and Asia-Pacific countries, *QJM: An International Journal of Medicine*, hcaa159
[15] Australian Government, Department of Health (2019) Health Workforce Summaries
[16] Department of Health (2020), Coronavirus (COVID-19) Novel Corona Virus 2019 Health Alert, Advice for People at Risk of Coronavirus COVID-19, Advice for Older People
[17] Department of Health (2020), Media Release Australians embrace telehealth to save lives during COVID-19

specialists. Telehealth provision of mental health care may be an essential support during physical distancing and isolation.

Clinical governance in aged care

One area the Royal Commission may wish to investigate is the relationship between clinical governance and the prevention and management of COVID-19 outbreaks in RACFs. The Notice[18] issued by the Aged Care Quality and Safety Commission to the approved provider of Newmarch House in Sydney identifies "an immediate and severe risk to the health, safety and wellbeing of care recipients at the Service" and notes serious concerns in relation to a number of Aged Care Quality Standards, including Standard 3 (Personal care and clinical care) and Standard 8 (Organisation governance). The information considered by the Commission included concerns raised by its COVID-19 Taskforce about the approved provider's "lack of suitable processes and systems in order to control transmission of the virus at the service".

The AMA's two previous submissions to the Royal Commission lists AMA members' concerns in relation to clinical care in RACFs. In this submission the AMA addresses some of these concerns.

Aged Care Quality Standards

As noted in the AMA's submission to the Royal Commission dated 30 September 2019, while the new Aged Care Quality Standards[19] include important principles such as dignity, respect and engagement of older people through obtaining their feedback on the services they receive, they are high level, subjective and potentially vague. More details can be found on pages 23-25 of the AMA submission. The AMA recommended that:

> *Recommendation 18: More specific Aged Care Quality Standards, including a Medical Access Standard should be developed for RACFs that help facilitate access to doctor services and high-quality clinical care.*

Training of aged care staff

Although the Department of Health should be commended for quickly developing online training resources for aged care staff, training of staff *during* a pandemic is not the preferred approach. Staff should have already been trained and prepared to manage an outbreak and then provided with refresher training once the threat arose. It is the requirement of the Aged Care Quality Standards to minimise infection risks. In particular:

> *Standard 3: Personal Care and Clinical Care*
> *Requirement (3) (g): Minimisation of infection-related risks through implementing:*

[18] Australian Government, Aged Care Quality and Safety Commission (2020) Information on Notice to Agree to Requirement
[19] Australian Government, Aged Care Quality and Safety Commission (2019) Guidance and resources for providers to support the Aged Care Quality Standards

a. standard and transmission-based precautions to prevent and control infection

Influenza outbreaks happen yearly in Australia, and it is often the elderly that are most affected[20]. Although COVID-19 estimates show a higher transmission[21,22] and case fatality ratio[23] than seasonal influenza, the training that the aged care staff should have had before this pandemic, including training to meet Standard 3 to prevent and control infection, would have better prepared them. Additionally, it was disappointing to see the Department of Health webinar "for residential aged care providers and their staff, on COVID-19 preparedness and prevention"[24] organised two months into the pandemic, presenting on topics that should have been part of regular RACF practices long before the pandemic.

Furthermore, under Standard 7, providers are required to provide induction and other training and development programs for all members of the workforce relevant to the Standards. In the AMA's view, prevention of infection training should be a core component of induction of anyone starting work in RACFs. Continuous training refreshers for RACF staff should also be required and facilitated.

In its previous submission to the Royal Commission the AMA argued that the new Aged Care Quality Standards do not specify the type of training that staff are required to undertake, which may lead to the drop in the standard of care for residents. The AMA warned that insufficient funds are directed for training purposes and that "risks associated with this approach include opting for shorter, less costly courses that do not provide sufficient training, higher turnover of staff, de-incentivisation of workforce, and a lack of opportunities for career progression for staff that are personally motivated to work in the aged care sector".

Government data supports the AMA's concerns. The 'Workforce and Quality' and 'Ageing and Service Improvement' programs are funded by State/Territory governments to ensure compliance with Quality Standards and that aged care staff are sufficiently skilled to provide aged care services[25]. While Government spending on aged care has increased by 27% since 2013–14 to 2018-19, workforce and service improvement funding dropped from 300 million to 100 million[26]. This is doubly concerning given that the number of people accessing aged care services increased, and people are increasingly entering aged care frailer and with multiple comorbidities.

[20]Australian Bureau of Statistics (2018) Causes of Death in Australia 2017, Deaths due to Influenza 2017
[21] Joseph T. Wu et al (2020), Nowcasting and forecasting the potential domestic and international spread of the 2019-nCoV outbreak originating in Wuhan, China: a modelling study, The Lancet, Volume 395, Issue 10225, P689-697, February 29, 2020
[22] R. Nikbakht et al (2019), Comparison of methods to Estimate Basic Reproduction Number (R0) of influenza, Using Canada 2009 and 2017-18 A (H1N1) Data, J Res Med Sci. 2019; 24: 67. Published online 2019 Jul 24
[23] Shigui Ruan (2020) Likelihood of survival of coronavirus disease 2019, The Lancet, Volume 20, Issue 6, P630-631, June 01, 2020
[24] Australian Government, Department of Health, Residential Aged Care COVID-19 Webinar, 8 May 2020 https://publish.viostream.com/app/s-n411ghp
[25] Productivity Commission (2018) Report on Government Services, Aged Care Services, Chapter 14, P14.7
[26] Australian Institute of Health and Welfare (2020), GEN Aged Care Data, Government Spending on Aged Care

The Royal Commission may wish to investigate further how the levels of staff, levels of trained staff, and the levels of adequate training of staff influenced the RACFs' monitoring and management of COVID-19 outbreaks.

Availability of registered nurses and trained medical staff

In its previous submissions to the Royal Commission, the AMA has repeatedly called for mandated minimum staff to resident ratios and the presence of registered nurses (RNs) in RACFs 24/7. In the AMA view, in the absence of a medical practitioner, RNs are the only aged care provider staff members that can provide frontline, timely clinical care within their scope of practice. The AMA has wholeheartedly welcomed the recommendations by the Royal Commission Counsel Assisting on minimum staffing ratios[27] and the recommendation for a minimum of 30 minutes of RN care time per resident per day.

The AMA has previously warned of the tendency for RACFs to minimise rostering of RNs. AMA members have also raised concerns with the AMA about RACFs with a high turnover of RNs and clinical care managers. More detail is provided in the AMA submission from September 2019.

Unfortunately, some of these problems persisted during the COVID-19 pandemic. As the recent ANMF survey of aged care workers[28] has shown, up to 80% of survey respondents reported no increase in staffing numbers during the pandemic, with some reporting further cuts to staff numbers since March 2020.

The AMA recommends that the Royal Commission also consider whether the high numbers of casual staff being employed in RACFs had a detrimental impact during the pandemic. In particular, the Royal Commission could examine whether the fear of losing pay resulted in at-risk or infectious staff without access to paid sick leave attending work and inadvertently spreading the virus. Some workers' unions have called on the Government to provide additional funding that would enable two weeks paid COVID-19 leave for aged care staff with symptoms[29]. On July 30 the Victorian Government announced one-off payments for Victorian workers, who are required to self-isolate or quarantine due to COVID-19[30].

Aged care workers who provide care at multiple RACFs were identified as a transmission risk, which lead to the Federal Government response and additional funding[31]. Research conducted in Canada concluded that ensuring adequate staffing numbers and limiting staff movement between multiple Canadian long-term care homes were key in helping to prevent the spread of COVID-19.

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[27] Royal Commission into Aged Care Quality and Safety (2020), Counsel Assisting Submission on Workforce, P34
[28] Australian Nursing and Midwifery Federation (2020) News, Aged care workers' inspiring efforts to keep older Australians safe despite challenges of COVID-19, published on Friday 8th May, 2020
[29] United Workers Union (2020), Media Release: Federal Government Must Act on Aged Care Safety, 18 May 2020
[30] Victoria State Government Health and Human Services, Coronavirus (COVID-19) Test Isolation and Worker Support Payments, 30 July 2020
[31] Department of Health, Ministers, Minister Greg Hunt Media, Media Release: Support for aged care residents and aged care workers across Victoria, 19 July 2020

Advance care planning

The COVID-19 pandemic has brought to the forefront the importance of having Advance Care Directives (ACDs), especially for residents of RACFs. As the Royal Commission's Background Paper on advance care planning has demonstrated, having an ACD can have multiple benefits for residents, from preventing unnecessary hospital transfers to reducing anxiety for residents and their families[32].

So far, Australia has been able to prevent and contain the spread of COVID--19 before the numbers of ill patients requiring hospital care became too high. The experience of other countries has shown that many doctors were forced to make difficult decisions about which of their patients would have access to ventilators[33]. Arguably, some of those decisions, by patients and doctors alike, could be made easier if patients had ACDs that specified their preferences regarding palliative and end of life care[34], should they lose decision making capacity.

An ACD specifying a person's preference not to be transferred to hospital in the event of illness should not prevent the resident being transferred to a separate area of RACF or a separate COVID-19 designated RACF to optimise their care. Where appropriate, residents should be encouraged, in a sensitive manner, to review and update their ACDs in light of the current COVID-19 crisis. In situations where there is significant uncertainty as to whether the terms of a resident's ACD was intended to apply to the current circumstances of acquiring COVID-19, the AMA believes decisions to transfer residents who have lost decision-making capacity and have tested positive to hospital should be undertaken in consultation with the resident's substitute decision-maker, taking into account the patient's ACD, the patient's known values and goals of care and the wider public health strategy.

The AMA has previously argued that advance care planning should form an integral part of person-centred care in aged care and that implementing and respecting ACDs should form an integral part of any clinical governance in aged care. The AMA has also previously advocated for a greater role for GPs caring for patients in aged care and for an MBS item to be available for GPs to complete ACDs with their patients living in RACFs.

[32] Royal Commission into Aged Care Quality and Safety (2019), Advance Care Planning in Australia, June 2019 P4
[33] D.B. White (2020) A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic, JAMA. 2020;323(18):1773-1774. doi:10.1001/jama.2020.5046
[34] J. Randall Curtis et al (2020), The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19), JAMA. 2020;323(18):1771-1772. doi:10.1001/jama.2020.4894

The role of Government and regulatory bodies

Centre for Disease Control (CDC)

The AMA has been calling for the establishment of an Australian CDC since 2017[35]. The COVID-19 pandemic has further demonstrated the need for an independent body that incorporates all communicable disease functions that currently sit with different areas of Government. The AMA believes that having a CDC would enable Australia to have a national focus on current and emerging communicable disease threats, and to engage in global health surveillance, health security, epidemiology, research and evidence-based policy making. A CDC would be able to manage pandemic threats in a more co-ordinated manner, thus making us better prepared for future outbreaks. A CDC would be useful also to direct the policy and provide general guidance and direction in any future potential outbreaks in RACFs. A CDC could also eliminate some of the overlaps and inefficiencies from the lack of coordination between the Federal and State/Territory administrations.

Intersections and overlaps between different jurisdictions

The outbreaks in Victoria have exacerbated the significant deficiencies of the aged care system and its coordination between Federal, State and Territory governments. The AMA has called for rapid improvement. The AMA believes there is an urgent need for a coordinated Federal/State/Territory proactive risk assessment and plan for all RACFs Australia-wide. This need is amplified by the fact that staff have been deployed from interstate to support Victorian RACFs[36]. Should a similar situation occur in another State/Territory in future, governments must ensure there is enough medical staff to fill that need. It is therefore crucial to act proactively and preventatively before it is too late.

The coordinated risk assessment using an appropriate risk assessment tool would need to be implemented to assess the ability of all RACFs in each State/Territory to safely cohort risk-infected residents and the capacity to provide supportive treatment to the residents within the RACF. This will be required to develop plans for each individual RACF that incorporate the potential impact of infected and isolated staff, including triggers for transfer and transfer destinations. The plan would also need to identify appropriate sub-acute RACFs where residents can be evacuated to in the short term, for those that do not need acute healthcare. In the AMA view the Federal Government should initiate a process of risk assessment and planning in coordination with each State/Territory to ensure each establishes its own specific taskforce as soon as possible.

To successfully manage future outbreaks there are some key steps that will need to be undertaken. Strengthening the relationship between health service in-reach teams (medical and nursing) is imperative. Greater coordination of the aged care response with health services and

[35] Australian Medical Association (2017), Australian National Centre for Disease Control Position Statement
[36] Department of Health, Transcript – Press Conference about COVID-19, Executive Officer of the Victorian Aged Care Response Centre, Joe Buffone and Clinical Lead for the Victorian Aged Care Response Centre, Professor Alison McMillan, – 31 July 2020

additional services such as ambulance and patient/resident transport services is required. Improved communication and coordination with families of RACF residents needs to be ensured continuously. Finally, GP inclusion and engagement is critical to planning and managing outbreaks.

The outbreaks in Victoria and in New South Wales (Newmarch House outbreak) have shown that to effectively manage COVID-19 in RACFs, substantially increased staffing is required[37], given the changed working conditions while following ID protocols and wearing PPE. In order to protect staff and residents from infection, and to be able to deliver acceptable standard of care, an additional acute increase in staffing ratios is essential.

Department of Health

In the trying circumstances that they faced, the Department of Health should be commended for its proactive approach during the COVID-19 pandemic, particularly the rapid development of resources for RACFs and their staff.

The Department and the Government should also be commended for the additional investment in aged care, with the total Government funding in response to the pandemic reaching $850 million[38]. The AMA has welcomed the Government investment and called for it to continue beyond the pandemic[39]. Being the chief funder and the regulator of the sector, the Government should take further action to ensure that the funds directed to the sector guarantee sufficient staff numbers and sufficiently trained staff availability, particularly in RACFs.

AMA members welcomed the guidance provided by the Department around management and prevention of COVID-19 outbreaks in RACFs[40,41,42]. However, AMA members expressed their concerns around some of the guidance. Specifically, the AMA's 30 April 2020 letter to the Department of Health and the Aged Care Quality and Safety Commission, called for the guidance to be improved by:

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[37] See for example the Senate Select Committee on COVID-19, PARLIAMENTARY INQUIRY QUESTION ON NOTICE, Department of Health Australian Government's response to the COVID-19 pandemic, 26 May 2020 PDR Number: IQ20-000265, which shows that the Department of Health has, through the workforce surge measure, provided 38 registered nurses to manage infection control in just one RACF – Newmarch House. On top of that, 15 General Practitioners on 24/7 roster (Department of Health funded) from the General Practice surge team through Nepean Blue Mountains Primary Health Network were brought in, plus two on-site General Practitioners from 30 April 2020 (Department of Health funded).

[38] Department of Health (2020), Senator the Hon. Richard Colbeck, Media Release: New COVID-19 payment to keep senior Australians in residential aged care safe, 8 May 2020

[39] Australian Medical Association, Media Release: Strong Investment in Aged Care Must Continue – AMA, 4 May 2020

[40] Australian Government, Department of Health (2020) Corona Virus COVID-19 Outbreak Management in Residential Aged Care Facilities

[41] Australian Government, Department of Health (2020), COVID-19 Guidelines for Outbreaks in Residential Care Facilities

[42] Australian Government, Department of Health (2020), COVID-19 Guidelines for Infection Prevention and Control for Residential Care Facilities

- **Lowering the threshold for COVID-19 testing in RACFs.** In the AMA view, testing of residents should start when the first resident has symptoms, as outbreaks in RACFs have the potential to spread quickly with large mortality rates. The AMA also fully supported the option of testing asymptomatic residents and staff if there is a positive case in the RACF.
- **Consistent national rules for testing of RACF residents.** AMA members noted that different states had different testing rules for RACFs. The AMA also noted that there was variation in the testing threshold across jurisdictions.
- **Improved guidance around the rules for cohorting of residents in RACFs.** The AMA suggested further clarification to allow operators to have designated COVID-19 RACFs, where COVID-19 infected patients are cared for by dedicated COVID-19 staff. The AMA suggested that specialised facilities which would be expertly staffed, well resourced, supported by GPs, palliative care nurses, palliative care physicians and geriatricians who can ensure that frail elderly residents do not suffer.
- **Improved guidelines around palliative care in RACFs.** The AMA called for improved guidelines around the obligations of RACFs to provide palliative care for COVID-19 patients. This was prompted by past experiences of AMA members with RACFs refusing to provide palliative care, on the basis of a critical nursing shortage. The AMA called on the Government to ensure that RACFs have adequate staffing and supplies of palliative medicine available. This includes provision of adequate IV treatments to RACF residents by nurses who are trained to administer it.
- **Improved guidelines around specialist appointments for residents.** AMA members have provided examples of patients in RACFs missing their external specialist appointments due to strict lock down rules implemented by some RACFs. The AMA called for clear guidance to RACFs and doctors to be provided which outlines what medical appointments their residents/patients should continue to go to.
- **Addressing workforce issues in rural and remote areas.** Finally, the AMA raised the issue of medical care provision in RACFs in rural and regional areas, where doctors, most commonly GPs, are required to staff hospitals, accident and emergency, and aged care. The AMA therefore suggested that a process for recruitment/training of younger doctors be established, who would visit RACFs and be supervised by the patient's usual GP via telehealth.

Aged Care Quality and Safety Commission

The impact of the COVID-19 pandemic in the aged care sector has brought to the forefront the need for a stronger role of the Commission. The AMA was somewhat surprised that at the start of the pandemic, the Commission announced that they would limit visits to RACFs for accreditation purposes and instead would telephone aged care approved providers to monitor their preparation for COVID-19[43]. While the AMA understands the need to protect Commission

[43] Australian Government, Aged Care Quality and Safety Commission, Message from the Commissioner COVID-19, 17 March 2020

staff, RACF staff, and residents, and to put in place physical isolation measures, issues of compliance and meeting the standards of care have never been more important.

The first funding package of $101.2 million that the Government announced on 11 March 2020 included additional funding for the Commission to work with providers on improving infection control[44]. The AMA supports funding for additional infection control in pandemics. However, the Royal Commission may wish to investigate the adequateness of funding and preparedness for outbreaks that existed before the pandemic occurred.

The complaints to the Commission from consumers have increased during the COVID-19 pandemic, raising concerns over providers' ability to meet needs. According to the Commissioner Janet Anderson's statement, the Commission received over 1,800 calls in March, a sharp increase from 1,298 in February[45].

In her statement before the Senate Select Committee on COVID-19, Commissioner Anderson said that the Commission had "received a very significant increase in the total number of complaints. The vast majority of that increase is attributable to the visitor restrictions"[46]. After the Government introduced restrictions in visitors to RACFs[47], which were reasonable and supported by the AMA, many RACFs implemented further restrictions that were beyond the requirements defined by the National Cabinet[48]. In the AMA's view, a complete banning of visitors in aged care could have potentially caused more harm than good, by having a detrimental impact on mental health and overall health of older residents. In many cases family members and friends provide care and support, including hygiene assistance and meals to residents. They also are important in raising any instances of inappropriate care.

Consumer choice and control are the fundamental principles of the Charter of Aged Care Rights and the Aged Care Quality Standards. The Charter describes the right of consumers to "have control over and make choices about my care, and personal and social life, including where the choices involve personal risk"[49]. In the AMA's view, implementing visitor restrictions beyond the requirements and advice of National Cabinet was not consistent with this.

The AMA was surprised that the Government and the Commission negotiated an Industry Code to "provide an agreed industry approach to ensure aged care residents are provided the opportunity to receive visitors during the COVID-19 pandemic, while minimising the risk of its

[44] Prime Minister of Australia, Media Release: 2.4 Billion Health Plan to Fight COVID-19, 11 March 2020
[45] Australian Government, Aged Care Quality and Safety Commission, Media Release: ACQSC Regulatory Response to COVID-19 Statement from Ms Janet Anderson PSM, Aged Care Quality and Safety Commissioner 02 April 2020
[46] Commonwealth of Australia, Senate Select Committee on COVID-19, Proof Committee Hansard, Australian Government's Response to the COVID-19 Pandemic, 26 May 2020
[47] Australian Government, Department of Health, News: Advice for aged care facilities and visitors to residents, 18 March 2020
[48] See for example this transcript of the media conference by the Prime Minister Scott Morison on 24 April 2020, the Prime Minister expressing Government's concerns about restrictions that are being put in place beyond what is required by the National Cabinet
[49] Aged Care Quality and Safety Commission (2019), Charter of Aged Care Rights

introduction to, or spread within, a residential care home"[50]. This code is voluntary, it is not a legislated obligation[51]. This means that non-compliance does not have consequences. The AMA would prefer to see the Charter of Aged Care Rights and Aged Care Quality Standards implemented by those agencies whose role it is to ensure compliance and that rights of consumers are respected.

AMA President, Dr Tony Bartone, provided expert testimony to the Senate Select Committee on COVID-19 on 25 June 2020, in which he took a question on notice as to whether further changes would need to be made to the Commission to address the shortcomings that have been highlighted during the pandemic. In the written response provided to the Senate Committee, the AMA argued for action from the Commission on the following issues, both during and after the pandemic:

- More specific Aged Care Quality Standards, including a Medical Access Standard that helps to facilitate access to doctor services and other high-quality clinical care;
- Increase the number of accreditation auditors who have experience in clinical care;
- Accreditation audits to focus more on quality care than documentation compliance – the accreditation process should ensure that quality of care is considered a more essential indicator of quality than the existence of paperwork;
- Work with aged care providers to improve their understanding of clinical care and practical implementation of clinical governance;
- Ensure that infection control is understood and implemented properly by RACFs and their staff;
- Ensure that RACFs implement infection control training frequently for all their staff – for example, any new staff member should be trained in infection control and regular refreshers of that training should be provided;
- Better manage and sanction the behaviour of RACFs that implement excessive visitation restrictions contrary to the Charter of Aged Care Rights; and
- Ensure that the sector employs adequate trained staff, particularly RNs, reducing the need to resort to external private companies as a surge workforce in aged care during a pandemic.

Conclusion

The AMA thanks the Royal Commission for the opportunity to comment on the impact of COVID-19 on aged care. The AMA acknowledges that the pandemic is still ongoing, and it may be too early to make any decisive judgements on how the Government and the sector have responded.

[50] COTA Australia, Industry Code for Visiting Residential Aged Care Homes during COVID-19, 11 May 2020
[51] Aged Care Quality and Safety Commission, Fact Sheet: The Industry Code for Visiting Residential Aged Care Homes during COVID-19

The AMA has broadly been very supportive of the measures, policies, and programs implemented by the Federal Government and the National Cabinet to manage the impact of the pandemic in this country. As a result of Government action and utilisation of medical experts and medical professionals when devising and implementing its programs, Australia has been one of the world leaders in combating COVID-19.

Aged care was struggling long before the pandemic started, with systemic neglect recognised by the Royal Commission. The AMA welcomes further inquiry by the Royal Commission into whether lack of staff, lack of staff training, inappropriate clinical governance and/or lack of involvement of medical professionals contributed to poor outcomes for residents and/or avoidable COVID-19 deaths in RACFs and, if so, the steps that can be taken to prevent and manage future outbreaks.

7 August 2020

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