EDITORIAL

COVID-19 and residential aged care in Australia

The COVID-19 pandemic continues to have far reaching impacts on individuals, professionals, human services such as aged care and, society more broadly. In Australia we are proud of our success in limiting the direct impacts the virus has on mortality and morbidity. When reflecting on this pandemic we must recall that 'success' has many parents - everyone clamours to explain that their actions created a positive outcome. In contrast 'failure' is an orphan—no-one steps forward to acknowledge their responsibility for an adverse outcome. The reality is Australia's success with the emergency response and management of COVID-19 pandemic are in a large part due to inherent underlying geographic and population factors. We live on an island continent with an extraordinary ability to control our borders. We have an extremely low population density and our population is widely dispersed. Also instrumental was our coordinated and prompt public health responses and community cooperation.

As of June 24 2020, nationally the total number of COVID-19 infections was 7,521 with 103 deaths comprising 29 aged care residents.[1] Internationally, Australia rates extraordinarily well on these metrics.[2] What we must guard against are complacency and overconfidence.

This is evident in efforts to thank aged care staff for working extremely hard. We conflate our words of gratitude with unsubstantiated statements about how well the whole aged care sector is operating. The absence of catastrophic impacts of the COVID-19 pandemic in aged care homes in Australia that occurred around the world are not evident of a highly functioning system. The virus has not washed away the systemic failures highlighted in the interim report by the Royal Commission into Aged Care Quality and Safety.[3]

While the COVID-19 pandemic exacerbates and highlights the existing primary failures[4] in the provision of residential aged care in Australia. We are distracted by the profound shift in our usual way of life, the fear and angst with confronting a once in a century natural disaster.

We require a prudent approach if we are to guard against the high COVID-19 case fatality rate of residents in aged care homes. This article is intended as a sober reflection at the structural domains of the aged care sector and the COVID-19 pandemic. The domains are governance, workforce, models of care, evaluation including the use of data and finally, resources and infrastructure.

GOVERNANCE

Governance or the lack thereof is a recurring issue in aged care. Good governance comprises following the rule of law, transparency and accountability for service provision. The COVID-19 pandemic highlight major gaps in this domain for the sector. There was a slow recognition of the extremely serious risk COVID-19 posed for older people and the multiple authorities involved, creating confusion and lack of consistency to optimally manage the pandemic.

The initial Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) did not reference the Royal Commission nor recognise aged care as a system that is failing in 'usual circumstances'.[5] At a federal level there are the regulators in Aged Care Quality and Safety Commission and two separate portfolios of government in health and aged care are involved. At a State level the Department of Health and Public Health Units as well as the providers for general practice and the acute hospitals.

This hampered development of a coherent policy and appropriate practice for a humane lockdown at each aged care facility. At a local level there was confusion for aged care providers and staff when an outbreak of COVID-19 occurred such as at Newmarch House.[6]

The lack of transparency in aged care was especially evident with the facility lockdown. Inability of families to visit their loved one was compounded by a pre-existing absence of a minimum standard of information about care delivery to residents. This type of public reporting that is user-friendly and easily accessible to consumers would have eased enormous worry for families and the community in general.

WORKFORCE

Much was made of the need to retain and upskill staff to manage the COVID-19 pandemic. Specifically, the need for residents to shelter in place and for facilities to be able to provide the additional clinical care. Recognition that the sector was understaffed and was not equipped to step-up service to that of an acute hospital was slow in being recognised and remains an issue. The federal government surge workforce initiative addressed aspects of these issues temporarily.

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What remains is a failure to address the long-term systemic issues highlighted again in a recent international comparison of aged care workforce. Eagar and colleagues report widespread and substantial gaps in the workforce which impacts on the quality of care for residents.[7]

The deskilling of the workforce by reducing the number of nurses employed in aged care homes continues to occur. The pandemic highlighted an unfair and unreasonable expectation that personal care attendants could and should 'step-up'. Asking personal care attendants to deliver highly technically care in an urgent and complex situation is bewildering given the entry requirements into this role is a very basic level of skill training.

This issue should have received a more robust public, aged and health care sector debate. As it goes to the essence of the standard of care for older people infected with COVID-19. The absence of a genuine resident voice is at the heart of this silence. A silence not overcome by boisterous peak bodies that represent providers, professionals or community dwelling older people.

MODELS OF CARE

The emergency response to the COVID-19 pandemic assumed that the existing model of care could readily adapt into an acute health model. The duality of purpose in residential aged care has not ever been satisfactorily resolved. Government, providers, health professionals, acute hospitals pivot around their preferred model of care to suit the immediacy of their argument. The workforce composition is predicated on a model of care that assumes aged care is a residence, a home to live in for well older people who occasionally need assistance with personal care. The reality is far different. A model of care must recognise that residents are frail older persons with cognitive impairment and multiple other comorbidities who are vulnerable to dramatic or life-threatening consequences from minor insults or injuries.

The older person in an aged care home has a diverse set of clinical, health maintenance and quality of life needs. The expertise for all aspects is unusual to find in one place.[8]

EVALUATION

The volume of data, statistics and tally counts during the first wave of COVID-19 were overwhelming. Sadly, there was little useful data to guide aged care. This was evident internationally in the United Kingdom and France with the incomprehensible failures to recognise or include the deaths of aged care residents in a nation's official case fatality count.

In Australia, information about the number of aged care facilities with an outbreak, how these were managed and, the lessons to be learned were and remain difficult to access in the public domain. Detailed, relevant, standardised reports about the quality of care being delivered to residents were largely absent. Mostly because prior to the COVID-19 pandemic this information is either not collected or if gathered not released. Information indicative of whether the aged care sector was coping requires examining measures of system distress such as the use of restrictive practice, resident mental health and wellbeing and those exhibiting severe responsive behaviours.

The existing data indicated pre-existing deficits in infection control that could have informed specific strategies to improve our national approach in aged care.[9,10]

RESOURCES AND INFRASTRUCTURE

The limitations in our resources and infrastructure have been largely overlooked. Patched over with temporising measures with surge workforce or staff stepping in to fill the void because of the urgency of the situation.

The existing building designs and stock for aged care homes create conditions for rapid spread of infection. Small bedrooms, shared bathrooms, communal areas and a 'home-like' environment that precludes the space and equipment to maintain meticulous infection control.

CONCLUSION

The aged care sector requires transformation. The havoc wreaked by the COVID-19 pandemic globally and nationally may create an environment where the required changes are lost to other priorities. We should remember that it was good fortune that allowed Australia's aged care sector to survive so well. That the second and subsequent waves require good management. That requires understanding the existing gaps and bridging these in the short term for the pandemic. To achieve long term changes requires vigilance and advocacy.

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REFERENCES

1. Australian Government, Department of Health. Coronavirus (COVID-19) current situation and case numbers. https://health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#at-a-glance (accessed 16 Jun 2020)
2. Comas-Herrera A, Zalakaín J, Litwin C, Hsu AT, Lane N and Fernández J-L (2020) Mortality associated with COVID-19 outbreaks in care homes: early international evidence. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 3 May 2020.
3. Royal Commission into Aged Care Quality and Safety. Interim report Neglect. October 2019. https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf (accessed 16 Jun 2020)
4. Ibrahim JE. Royal Commission into Aged Care Quality and Safety: the key clinical issues. *Med J Aust*. 2019; 210(10): 439-41.e1 doi.org/10.5694/mja2.50168
5. Australian Government, Department of Health. Australian Health Sector Emergency Response Plan for Novel Coronavirus. https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf (accessed 16 Jun 2020)
6. Snow D. The perfect storm: how COVID-19 unleashed chaos inside Newmarch House. *The Sydney Morning Herald*. 16 May 2020. https://www.smh.com.au/national/nsw/the-perfect-storm-how-covid-19-unleashed-chaos-inside-newmarch-house-20200515-p54t9d.html (accessed 16 Jun 2020)
7. Eagar K, Westera A, Kobel, C. Australian residential aged care is understaffed. *Med J Aust*. 2020; 212(11): doi.org/10.5694/mja2.50615
8. Ibrahim JE. Residential aged care: there is no single optimal model. *Med J Aust*. 2018; 208(10):431-2. doi.org/10.5694/mja18.00268
9. The Aged Care Quality and Safety Commission. Sector Performance Data 1 October – 31 December 2019. https://www.agedcarequality.gov.au/media/88018 (accessed 16 Jun 2020)
10. 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*. 2019;38(1):60-3. doi.org/10.1111/ajag.12595