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Submission to the Royal Commission for Aged Care

Impact of COVID-19 on Aged Care services

July 2020

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,000 physicians and 8,500 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, infectious disease medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

- **Geriatricians**. Geriatricians are specialists in understanding the needs and challenges of an ageing population. They are trained to identify and assess decline or the need for decline preventing strategies in an older person. Such strategies are critical to minimising or reversing any negative impact on function affecting their own or the community's safety.
  Geriatricians take a multidisciplinary team approach to healthcare for older persons, always endeavouring to work with GPs and other health professionals such as nurses, physiotherapists, occupational therapists, speech pathologists, dieticians, psychologists, social workers and pharmacists. Geriatricians promote and prolong older persons' capacity to safely remain at home. Their role and appreciation of the impact and complexity of multi-morbid conditions on older persons should be considered central to supporting carers and patient decision-making. Geriatricians contribute to the care of older people across the care continuum; from Memory Clinics and community care at home, through emergency, acute and subacute care, including rehabilitation of older Australians.
- **General and acute physicians.** General and acute physicians treat elderly patients with acute illness and are also specialists in multimorbidity and the management of chronic disease. Patients may be residents of aged care facilities or transitioning from hospital to an aged care facility from hospital. General and acute physicians can also provide care to adults with intellectual and or physical disability, including adults with congenital or acquired brain or physical disability and those with neurodegenerative conditions affecting them in childhood or early to middle aged adulthood. Adult patients with intellectual or physical disabilities may need to be treated in the different residential and care contexts (aged care facilities, as part of younger families, with ageing parents, in group homes, in supported accommodation).
- **Infectious disease physicians.** Infectious disease physicians specialise in infections of the body, understanding and treating the various clinical, laboratory and public health aspects of infectious diseases medicine and microbiology. They have an essential role in treating infectious patients, controlling infection and advising on the risk of spread.
- **Public health physicians.** Public health physicians work to improve the health and care of population groups and communities at large. Public health physicians develop strategies to support the implementation of programs for preventing disease and promoting the health of communities. Their training includes health promotion, the prevention of disease and illness, the assessment of a community's health needs, and the provision of health services to communities and research. Their role in responding to the COVID-19 pandemic involves advising on case detection, case isolation, developing ways of addressing public health issues, identifying close contacts, quarantine and containment strategies and managing clusters and outbreaks.
- **Neurologists.** Neurologists are involved in the diagnosis of dementia, including determining the probable underlying cause in younger people (Huntington disease, Frontotemporal dementia and Alzheimer disease) and older persons. Neurologists will see disorders that present in other ways and evolve to include dementia as a major feature e.g. Parkinson's disease, Huntington disease. They are involved in addressing safety issues (such as driving) and recommendations for NDIS or My Aged Care registration.
- **Occupational physicians.** Occupational physicians provide advice to or about aging workers including aging health care workers. They also have a role to play in providing advice to health care workers on fitness for duties or how to implement public health advice into day to day working routines
- **Rehabilitation medicine physicians.** Rehabilitation medicine physicians diagnose, assess and manage individuals with disability or functional decline due to injury, illness, chronic disease or ageing and work together with these people to achieve their optimal level of functional ability, social participation and quality of life. They are trained in the rehabilitation management of older people including those who have impaired function due to frailty and geriatric syndromes, debility and deconditioning, and chronic diseases or other complex health conditions. They are also trained in the rehabilitation management of all people with severe and permanent disability who may reside in aged care facilities, including younger individuals. Further, retention in and return to work rehabilitation programs are an important part of care of older persons with longer work requirements.

- **Palliative medicine physicians**. Palliative Medicine provides specialist care of people with terminal illnesses and chronic health conditions in community, hospital and hospice settings. Palliative medicine physicians work collaboratively with a multidisciplinary team of health professionals to provide end of life care, provide relief from pain and symptoms of illness, and optimise the quality of life for a patient.[1]

[1] The RACP acknowledges the input it has received to this submission from various specialty societies, in particular the Australia and New Zealand Society of Geriatric Medicine and the Australian & New Zealand Society of Palliative Medicine.

Executive Summary

The Royal Commission into Aged Care Quality and Safety has provided an important opportunity for the Royal Australasian College of Physicians to share what we know of the impact of the coronavirus (COVID-19) on the aged care sector.

As a peak body representing over thirty different medical specialty areas, the RACP will work with all levels of Government to improve services for older persons, and specifically medical care, so that the harm and potential for harm to older people related to COVID-19 is minimised and high quality, responsive and timely care becomes the sustainable standard.

For older people in these pandemic circumstances, the key concerns are:

- To reduce risk of spread especially in institutional environments, among all persons, including staff
- To reduce delays in condition diagnoses, assessments and treatment (including multidisciplinary treatment)
- To improve communications at all levels to facilitate timely medical decisions, including the infrastructure and pre-determined processes for this
- To reduce the rates of preventable hospitalisation of older people (who may be vulnerable for a range of reasons, to the risk of infectious diseases, disruptions from medication changes etc) [2]
- To approach infection control in residential aged care facilities (RACFs) with a similar attention to procedure as do hospitals. This might be achieved by creating separate medical care spaces for older persons for treatments, i.e. separate from residential care facilities. This would reduce the risk within an RACF, and should be organised to enable appropriate family support, communication and contact
- To enhance palliative medicine provision
- To promote and facilitate advance care planning
- To reduce risks of condition deterioration or exacerbation by providing home care with minimal wait times to support priority needs
- To ensure that the healthcare and other needs of the majority of older persons who live in the community are also well addressed, so that they can maintain optimum health and well-being, bearing in mind that community connection is equally important.

This submission describes the frontline experience of physicians, who are trained in complex care, throughout the COVID-19 pandemic. This experience addresses firstly, serious concerns about Residential Aged Care Facilities (RACFs) and secondly, experience relating to hospital and community care. Our messages are intended to raise the overall level of safety and care to reinforce equity.

Although some organisations responded well, in view of the clinical risks COVID-19 presents for older persons and also the healthcare team, there are a range of responses that can be initiated now.

The actions needed, that are contained in this submission, take into account the following themes:

1) **Older people are not homogeneous**. This diverse and large section of the population includes older Aboriginal and Torres Strait Islanders, culturally and linguistically diverse people (CALD), people with disabilities, people with dementia, the carers (who may be older persons themselves), people requiring palliative care or wound care, older people with multiple chronic conditions, people with mental health conditions, and people with restricted movement capacity.

2) **Aged care does not operate as a unified system**. It has many disparate components that have different incentives and reinforce different outcomes. Rising demand subject to capped activity can lead to cost cutting that is highly risky for patients in a high need situation such as the coronavirus pandemic.

[2] *The geriatric nursing home population is vulnerable to acute and deteriorating illness due to advanced age, multiple chronic illnesses and high levels of dependency*. Graverholt B, Forsetlund L, Jamtvedt G. Reducing hospital admissions from nursing homes: a systematic review. BMC health services research. 2014 Dec 1;14(1):36.

RACFs would be better prepared to respond to older persons with symptoms or who test positive to CIVD-19 if they were able to develop links with infection prevention teams (based in hospitals), any local public health units and pathology or microbiology services.

As we move through COVID-19 the Commonwealth Government should in cooperation with State and Territory governments, better link RACFs with hospitals that provide outreach services and other relevant bodies as noted above. This would allow trained paramedics and nurse practitioners to assess and assist RACF nursing staff to treat patients in the RACF who have acute but uncomplicated illnesses and also ensure that RACFs can better manage and care for their especially vulnerable patients during this pandemic period.

3) **Aged care relies on a qualified and maintained workforce**. A high priority remains for the Commonwealth Government to increase the number of appropriately qualified physicians and advanced trainees in ambulatory and community settings.

4) **The benefits to older people of telehealth and other non-contact technology**. Physicians have reported many benefits to older people since the introduction by the Australian Government of expanded telehealth MBS items (see press release, and telehealth survey results). Telehealth has been particularly helpful for patients who find it a challenge to attend appointments in person such as those with mobility issues, immune-suppressed patients, those living in rural and remote areas and Indigenous patients who feel more culturally safe attending appointments in their own environment.

Introduction

On March 11, 2020, the World Health Organization declared the SARS-CoV-2 (COVID-19) outbreak a pandemic. At the time, the Royal Commission for Aged Care Quality and Safety (the Commission) was in progress and had released its Interim report. The Commission announced a review of the impact of COVID-19 on residential and home aged care at the end of April 2020.

The College represents expertise in condition complexity and age-related health care which spans geriatric medicine, palliative medicine, sleep medicine, internal medicine; general and acute medicine, public health medicine, and prevalent condition related specialties such as infectious diseases, cardiology, neurology, endocrinology, rheumatology, neurology and oncology, rehabilitation medicine. The complex nature of the co-morbidities, including behavioural conditions, means that it is essential for multi-disciplinary care to be supported, where it is beneficial to the patient.

Prior to the onset of COVID-19 the RACP considered the infrastructure of the aged care system to be inadequately resourced to safely and effectively meet present and future demand. The RACP has previously stated to the Commission there are many aspects of aged care that consultant physicians consider do not meet the Australian Government's objectives for aged care services (refer RACP Submission December 2019).

Any components that are less than the best evidence-based care will be critical to a vulnerable group in a high risk situation – older persons being one of the highest at risk populations (for instance before COVID-19 hospitalisation rates for older persons were four times that for younger groups). [3] Avoiding increased rates of hospitalisation at such a time is vital.

Many providers at all levels of the health care system have responded admirably under unusual, emotionally challenging and pressured circumstances. The College advocates a non-judgemental approach be adopted in addressing any deficiencies in service provision so that vital services are encouraged, and people can seek assistance and guidance rather than fear castigation or stigmatisation.

While we are in the midst of a pandemic with the ongoing threat of outbreaks, and with the future possibility of other pandemics, it is prudent to act now. The nature of this pandemic requires mechanisms in the healthcare environment to reduce the risk of exposure and transmission, among the vulnerable population and among those that deliver vital care. This submission offers the experience and advice of physicians to achieve these objectives.

Medical risks faced by older persons during this pandemic and their implications

The following are the special risks faced by older patients who are being treated during this pandemic. These are not intended to be exhaustive:

Physical risk. Older persons are at the highest risk level of experiencing severe disease, hospitalisation and death from COVID-19. This risk has been reported as rising progressively with age, being much higher for over 70-year old persons. The risk is also higher for those with underlying medical comorbidities.[4] In particular the case fatality rate for those over 80 has been reported as over 15 %.[5] The highest risk of fatality then is among long term care residents who are among the oldest concentrated age group in close quarters.

Risks due to delayed presentation. It is imperative that early assessment and the comprehensive identification of health care needs for older persons occurs in a timely, expedient way. Already in Australia

3 McPake B, Mahal A. Addressing the needs of an aging population in the health system: The Australian case. Health Systems & Reform. 2017 Jul 3;3(3):236-47.

4 Holt NR, Neumann JT, McNeil JJ, Cheng AC, Unit HE, Prahan V. Implications of COVID-19 in an ageing population. The Medical Journal of Australia. 2020 May 6:1.

5 Wu, Z, and McGoogan, JM. Characteristics of and Important Lessons from the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72,314 Cases from the Chinese Center for Disease Control and Prevention. JAMA published online February 24, 2020. doi:10.1001/jama.2020.2648

non-COVID medical issues have delays (for example, delayed presentation and management of other acute medical issues, including acute coronary syndromes and stroke, and the sequel of elective surgery postponement [6]).

Immunosenescence. Vaccines (such as the SARS-CoV-2 vaccine) may not translate into lasting immunity in an elderly population due to immunosenescence (the deterioration with age of the body's immune system).

Adverse effects. There are risks associated with non-validated therapies to treat COVID-19, such as hydroxychloroquine and azithromycin, for elderly outside a registered clinical trial due to increased risks of adverse effects common to most drugs when used in the elderly (such as ventricular tachyarrhythmia, and sudden cardiac death).

Asymptomatic transmission. This is a constant threat to older people. In care areas and in the wider community surveillance must not be restricted to only symptomatic individuals.

Mental health. Mental health and the treatment of existing mental health issues should not be unnecessarily delayed. In these circumstances of reduced contact and isolation, untreated mood disorders can contribute to increased suicide rates in older Australians, which is more likely among men aged over 85 years.[7] Also see *Social isolation and depression* below.

Attention to the mental health and social and emotional wellbeing and health for Aboriginal and Torres Strait Islander people in the context of integrated services continues to be important under COVID-19 triggered circumstances.

Social isolation and depression. Health policies of social distancing and restricted visitation in care facilities, to limit potential COVID transmission, also increase the risk of symptoms of depression and anxiety in susceptible individuals. Two factors are noted here:

- Social stimulation is important for reducing cognitive impairment and maintaining wellbeing and physical function
- There are increasing numbers of older people living alone in our communities.

Regardless of COVID-19, there is a need to explore accommodation options for single older persons or couples with few family members close by, and promote community connectivity, especially those from non-English speaking backgrounds.

Given the medical risks as outlined above, it is important to ensure that the following constraints do not compromise care of elderly patients during this period:

- **Allocation of resources**. Healthcare resources within this and any other pandemic will likely be stretched. The approach to resource allocation must be and must be seen to be open and transparent.
- **Shortages of pharmaceutical supplies** This requires special mention in addition to overall health care resource allocation. Strategic forward planning of meeting pharmaceutical needs must take place. This is critical for a range of patient care needs, one example being patients in palliative care
- **Carers of older persons.** Older persons may well be increasingly reliant on carers. Carers will need education and access to resources and support

It is also important to be cognisant of **health workforce risks** and in particular the age of the health workforce. In Australia in 2018, the average age of practicing general practitioners and specialists was 49.9 - 51.1 years.[8] Protecting all members of the health workforce is important, however older healthcare professionals are also vulnerable and this can be a complex challenge to strained health infrastructure in need of this expertise.[9]

6 Holt NR, Neumann JT, McNeil JJ, Cheng AC, Unit HE, Prahan V. Implications of COVID-19 in an ageing population. The Medical Journal of Australia. 2020 May 6:1.

7 Australian Bureau of Statistics, Suicide in Australia 2015

8 Australian Government Department of Health. Health Workforce Data. Canberra AJ, 2019. Available: https://hwd.health.gov.au/summary.html#part-1. Accessed: April 25, 2020

9 Holt NR, Neumann JT, McNeil JJ, Cheng AC, Unit HE, Prahan V. Implications of COVID-19 in an ageing population. The Medical Journal of Australia. 2020 May 6:1.

Some important steps actions have been undertaken during COVID 19 to address this such as the option to use telehealth consultations. For older persons at risk it is essential that accessibility to timely care and the capacity for clinical decision making is not obstructed by avoidable barriers. For example, shortages of trained healthcare workers can result from pandemic workload, illness, isolation and quarantine. We draw particular attention to palliative medicine in this context.

Key issues

1. Safety and healthcare in Residential Aged Care Facilities (RACFs)

Residents in RACFs are in a reliant and somewhat dependent position and must place their trust in management. Residents should be regarded as members of the community for whom healthcare must be equitable and accessible.

RACF residents are at high risk of serious illness and death from COVID-19. It is therefore critical that RACFs meet Communicable Diseases Network Australia national guidelines for public health authorities, residential care services, health care workers and carers to manage COVID-19 outbreaks. The service providers must be prepared, respond rapidly and intervene early to CODID-19 response. These facilities must be supported by the Public Health Units and the relevant state or territory Department of Health.

In the table below, the nature of the concerning issues experienced by physicians is described, and remedial action is proposed.

Issue	Problem	Action needed
Essential Supplies	Overcoming inadequate supplies of Protective Personal Equipment (PPE). This has been an ongoing concern, for all health care provider staff in RACFs and the recommendation here pertains to both now and post pandemic.	RACFs to maintain an appropriate stockpile of PPE supplies for aged care facilities at all times (and not only during declared pandemics.
Physical space for patients and Infection control	The layout of facilities may pose their own issues for contained treatment. There is a shortage of patient care space should there be a further outbreak, such that physicians consider existing facilities will not cope. Additional facilities are needed that are designed and equipped to: • Contain the spread of outbreaks in facilities • Provide appropriate physical distancing and support, infection control practices at all times • Protect existing facilities from collapse • Provide high quality palliative care • Facilitate family presence (e.g. where patients are dying) subject to appropriate planning and infection controls Such additional units preserve the rights of other residents not to be exposed to contamination risks; respond to patients with an advanced care directive stipulating they do not wish to go to hospital; and for those in a final illness stage, should be in a position to include a family presence (as appropriate and with due regard for PPE, infection control and trained staff).	Prepare **additional equipped units**, with PPE, oxygen and access to palliative care medications. All RACFs should have in-house (or access to) infection control expertise, and comprehensive outbreak management plans in place. Recommend that an infection prevention control practice be established in RACFs.

	An infection prevention control response practice should be in place in RACFs given that residents are at high risk of serious illness and death from COVID-19.	
Sites for managing positive patients	An absence of guidance on whether COVID-19 positive patients should ideally be managed in the RACF or in hospital was experienced. RACFs had a low capability of physically cohorting (i.e. grouping people who may have been exposed to COVID-19) potential COVID-19 residents in RACFs after hospital discharge. Any structural renovation, reconstruction or expansion of RACF facilities should address the need for optimum infection control as a priority.	The Department of Health to provide specific agreed advice on this direct to RACFs. Designated patient spaces must be determined and the agreed approach communicated to the health workforce. Site planning and building changes must address the need for infection control.
Testing, that must include potentially asymptomatic staff	Containing the potential for any spread through staff. Asymptomatic staff or minimally symptomatic staff working with patients before being diagnosed present a risk.	Consistent and inclusive testing of the RACF workforce. If any patient or staff tests positive for COVID-19 then immediately test all remaining staff and residents.
Workforce	Current staffing levels in RACFs need to be addressed. This is not a new issue but this kind of pandemic triggered strain must be mitigated against. Maintaining some level of consistency in staffing at the level of RACF coordinator or middle management to ensure clear lines of communication is essential. The need for a resident doctor in the RACFs in the event of an outbreak was highlighted when most of the coordination with outreach teams and the Public Health Unit (PHU) was described as being done through the resident doctor. Insufficient staff with the added workload, compounded by shortages because of those that had to isolate. Care was needed to respond to for the risks to the aged care workforce, not just infectious disease risks, but also to the potential stress from: • Caring for affected residents, sometimes seeing them die • The risk of infection to themselves and their families • Exposure to abuse from families restricted from seeing their elderly family members. Residents and staff were impacted by some risks to their safety with regard to working practices. There can be unintended consequences from pre-COVID-19 rostering practices that contribute to incentives for staff, especially casual staff who may work at multiple facilities, to continue working. This warrants attention by RACFs so that the safety of all, both residents and staff is optimised.	Review, resource and improve staffing levels in RACFs. A register created and a funding bank (we understand this may be underway). Consider the value and convenience of a resident doctor in RACFs. Organise for supplementary staffing to deal with the added workload plus shortages from those that were in isolation. Sensitive management of staff, education on risks of debilitating stress, allow for better rostering practices. Consider and address working conditions that place residents and staff at risk.

Training of staff	In RACFs the training of staff was variable and could be limited when it came to: • The correct use of PPE • Swabbing • Infection control practices • Looking after a patient in isolation • Managing meals and other activities in group and shared areas. There were times when staff who had been trained in telehealth were not at work or ceased work (tested positive, other commitments, feared exposure, resigned, otherwise ill etc) and there were temporary staff on site who had not been trained in PPE or outbreak management.	Access of staff to training, or on the job designated mentorship, including incoming 'replacement or supplementary' staff.
Protocols	There was a clear need for single sources of critical information: • Clearer guidance on RACF outbreak/ pandemic management that also outlines cohorting, quick training of redeployed staff, and a handover manual to ensure continuity of care despite an outbreak. • Robust pandemic/ outbreak plans for RACFs and LHDs, in collaboration with the Public Health Units (PHUs) are needed, with options for deploying experienced medical and nursing staff as required e.g. RACF working parties have been developed in some LHDs with regular meetings with the local RACFs and clinicians able to update on changes to guidelines and provide assistance in a timely fashion. • There was no single authoritative source of information where there are delays in information flow from senior levels of corporate management. Low agility in transitioning to an infection control environment and varied response measures was a problem because it can lead to: • Ad hoc operationalisation of infection control measures. • High variability in cordon sanitaire measures e.g. from some centres excluding all people (as well as healthcare workers) to allowing some visitors and healthcare workers. • Risk of transmission of disease through shared communal spaces.	Develop RACF outbreak/ pandemic management guidelines. Prepare pandemic/ outbreak plans that allow for deploying experienced medical and nursing staff as required. This can be addressed by standard operating procedures and awareness of source documents.
Risk assessment and treatment	Delays in healthcare in RACFs risk condition exacerbations, increase pressure on staff and heighten any resident/patient frailty. There are a range of reasons for less than timely care noted in this submission. Models of care in RACFs should include physician assessment in person or remotely. Patients in these facilities are sometimes visited by geriatricians, but many require management by other specialists due to co-morbidities or precautionary measures, e.g. rheumatologists and neurologists and this requires	Minimise delays in healthcare. Improve access to physician care including special provisions such as telehealth, and system support for physician to

	family arranging a visit which can be very challenging if there is considerable disability. This may require considerable time off work.	physician conferring for rapid decision-making.
Standard of medical and therapeutic care	Ensuring the highest standards of medical and therapeutic care are able to be maintained in residential and home aged care.	Clinical expertise involved in pre-planning protocols.
Isolation and impact in cases of less robust health and well-being	Some people with suspected Covid-19 and placed in isolation, have had limited means of communicating with staff. Physicians have heard complaints of feeling abandoned. Balancing the need for safe socialisation is important in RACFs and must not be overlooked: • Many elderly people have experienced isolation with little contact. • Being confined to rooms for extended periods during the pandemic can lead to deconditioning. • The restrictions on relatives to RACF may have resulted in poor physical (dehydration, undetected infections) and mental health outcomes, as relatives often help feed the residents, monitor signs and symptoms and provide emotional support. • Staff have avoided interactions with residents until their COVID-19 swabs were cleared.	Stronger action or directives are needed from Federal Health Ministry to RACFs on issues such as isolation, admission, and visitor restrictions. The goal is to reach a balance between COVID-19 restrictions and allowing access of patients to family and care that is measured by actual COVID-19 cases or presence of an outbreak.
Palliative medicine	The accessibility of Palliative Care services to people in RACF's can be improved. Residents of RACFs have a right to access specialist palliative care when they need it. In particular [10] • Prompt communications providing updates and responses to queries in times of visitor restrictions is essential. • During the COVID-19 pandemic, a resultant shortage in the supply of palliative care medications must be anticipated. • Clinicians may need guidance regarding alternative medications and routes of administration in service organisations. Shortages of trained Healthcare Workers (HCW) can result from pandemic workload, illness, isolation and quarantine. There is an urgent need to train and empower non-palliative care health professionals to effectively deliver palliative care. Education and resources to support appropriate prescribing and administration of palliative care medications will be critical.	Education for RACF staff AND support for Community Palliative Care Services to provide an equitable level of care for RACF residents is crucial. Mitigate against shortages in standard delivery regimes of conventional first-line palliative care medications (e.g. morphine, midazolam). Alternative medication guidelines to be developed in the event of shortages. This is particularly important during COVID-19 situation where movement of people between RACF and acute hospital may be discouraged. Train non-palliative care health professionals to effectively deliver palliative care to counter likely shortages.

[10] http://www.anzspm.org.au/c/anzspm?a=da&did=1005077&pid=1587788101; Essential PEOLC in the COVID-19 pandemic

	Carers have been critical in this context. Education and resources for these carers is necessary to support their provision of care.	As early as possible assure carers with resources and guidance.
Culturally appropriate care for Aboriginal and Torres Strait Islander people	Responsiveness and sensitivity to culturally appropriate care needs for Aboriginal and Torres Strait Islander people in consultation with local communities is essential for older people and it is important health care providers are both reminded of this and are able to implement it.	All RACFs should be prepared for providing culturally appropriate care for Aboriginal and Torres Strait Islander people in consultation with local communities.

Frontline experience of Physicians: points of note

Further to the above issues, the RACP includes the following observations, adding to the points made in the above table:

There is inadequate experienced staffing in RACFs to manage a surge in activity from an outbreak, requiring deployment of staff from the LHDs unfamiliar with RACF processes.

Pandemic plans are not robust enough, for example, there is inadequate guidance on the cohorting of positive residents COVID-19 or those that are suspect.

The need for improved communication channels and clear points of contact between clinical providers (RACFs,) and public health units and the Department of Health (for example, there was uncertainty on how RACFs, local doctors or outreach services could contact public health units).

There is poor awareness of existing geriatric outreach services that could have assisted earlier in outbreak management.

Linkages and relationships between infection prevention teams (such as are at hospitals), any existing local public health units), pathology/ microbiology providers and RACFs can be significantly improved, according to our member experience. Stronger linkages would support better responses for symptomatic or positive patients in RACFs.

Some RACFs successfully contained the virus to one or two residents and prevented an outbreak, however, this good work was not disseminated and made known in media reports, which might have helped others.

There was discord between hospital and RACF policies on admission and re-admission policies. For example, hospitals could not transfer back residents or admit new patients to RACFs due to their strict COVID-19 requirements. RACFs required COVID-19 swabs on admission or transfer back but these were not consistent with ministerial directives on appropriate swabbing. Under the circumstances, a letter from LHDs still did not convince the private RACFs to take patients back.

RACFs significantly restricted visits. This measure, although understandable, in effect prevented the families of new admissions from reviewing RACFs before transfer. A significant number of new admissions were delayed then because families refused to permit transfer without access or visiting capacity. This decision was made by individual RACFs.

2. Hospital and community care

Aged care ideally should be characterised by competent, expert decisions able to be made about diagnosis, treatment priorities using current information and informing all those involved. A fragmented health system is a risk to vulnerable older persons in a pandemic.

Although there was considerable media focus on RACFs, community based older persons were also experiencing restricted community services and difficulties in accessing community and/or healthcare services. These needs should not be overlooked.

Issue	Problem	Action needed
Access to timely expert advice	Non-contact technology[11] has not become an upscaled, embedded part of the health care system infrastructure in ways that might maximise the benefits to older persons.	The DoH should review ways to improve non-contact technology accessibility to older persons (e.g. tuition, subsidised equipment etc)
Pathology	Usual models of care such as visiting GPs and mobile pathology collectors who would normally conduct swabs and imaging were disrupted or completely unavailable in some cases, due to COVID-19 restrictions.	Make forward alternative provisions for critical disruptions to services such as pathology collections and imaging.
Hospital admissions and transfers from RACFs	Reducing avoidable admissions, for non-COVID related reasons, where possible is important for this vulnerable population. This can be done through more integrated care models, communications infrastructure and fewer prohibitions for care sharing across health care sectors, e.g. physicians able to be located in ambulatory care settings. There is a need for a clear protocol for transfer from RACFs to hospitals of suspected COVID19 cases. There should be testing of those transferred from hospitals to residential aged care facility (RACF).	Commence introducing chronic complex care models in the community that connect specialist and GP care. Prepare protocols or standard operating procedures for transfer from RACF to hospitals of suspected COVID19 cases. Standards need to state COVID 19 testing is required of persons transferred from hospital to RACFs.
Home care support	Home care support is critical to: • Hospital avoidance • Containing health system costs • Circumventing illness escalation or exacerbation • Avoiding admissions to aged care facilities that are already under strain avoidance, especially for older, disabled and frail persons. The current wait time is far too long.	Home care support needs to be comprehensive, coordinated, timely, and coordinated by the ACAT system. The causes of long wait times must be closely examined because demand is not expected to decrease in the near future.

[11] This refers to technology which can facilitate patient-clinician interaction without face to face contact and includes but is not necessarily limited to various forms of telehealth technologies.

	During COVID-19 we understand there has been varying provider willingness to attend client homes to provide services. There were significant reductions in home care assistance further isolating aged care clients.	Develop provider awareness, standard guidelines for protective service delivery and training videos to overcome reduced service provision in times of need. This could be a requirement of being a registered supplier.
Incentivising health care professionals to provide services to rural and remote communities	In rural and remote areas older persons and their carers have less equitable access to needed health care and advice. Delays in healthcare increases the risk of condition exacerbations and places more pressure on carers and their health and well-being, and risk of frailty to both patient and carer.	Put in place workforce incentives and maintain new MBS telehealth items. There could also be a temporary pandemic roster plan. Telehealth items should be maintained because of the risk of further outbreaks of COVID and high impact viruses, and because of the other benefits identified of expanding access.
Bolstering and maintaining proactive, preventative and restorative care	The assessment, management and documentation of older persons needs, irrespective of point of care (such as impairments and experience of pain, pharmaceutical oversight), and including systemic protections for the vulnerable can assist in offsetting exposure to risk during a pandemic. Patients need to have clear linked pathways for care continuity.	Reinforce the essential nature of the clear documentation of older persons needs in treatment plans and records, irrespective of point of care, for ready reference in times of need. Health services (Primary Health Networks and Local Hospital Networks) should have clear linked care pathways.
Communications between health professionals across health sectors	Poor lines of communication were experienced between PHNs, LHDs and care facilities especially when staffing changed due to usual managers also being quarantined. The pressing need to establish purpose designed models and pathways of care that engage appropriately skilled teams (where teamwork is of benefit) or connect health professionals, that are able to communicate from different locations or portals has been experienced once again. A major issue during the pandemic, has been the need for a more holistic approach to health. Staff have attended to physical needs, but have often been too busy to manage disconnection and loneliness while family and friends have not been able to visit. Our information suggests that many residents did not receive proactive support to communicate with loved ones by phone or other remote technology.	Communications across health units and sectors must be improved. Introduce as soon as practical more connected models of care ahead of crisis situations. Aged Care facilities would benefit from a holistic model that includes all aspects of health, including quality of life issues such as recognising communication issues related to deafness and language, assistance with communication outside of the facility with family. Outreach programs involving physicians

		prepared to visit rural communities and work with nurse practitioners could be developed.
Improve continuum of care	Barriers to information flow were experienced during COVID 19. The electronic patient record in principle can assist with the sharing of medical records and avoidance of fragmentation.	Infrastructure to support connectivity across organisations and health care sectors is imperative).
Advance care planning (ACP)	Advance care planning and directives (ACP/ACDs) have not been promoted enough. Proactive management and Advance Care Planning (ACP) have never been more important. This needed more recognition according to some members. A system for ensuring that ACP's are accessible to acute hospitals when a patient is transferred would be extremely valuable. This might take the form of a central registry as currently being investigated by the Australian Digital Health Agency[12]. Example case situation: a person arriving at an Emergency Department in acute distress needs prompt treatment. Without almost immediate access to the content of an ACD, staff may have little option but to default to treatment.	The importance of Advance Care Planning (ACP) must be communicated. Sensitively promote the need for advanced care planning. Acute hospitals must have access to ACPs – a central registry may be useful.
High risk groups including dementia care **And medications that pose risks of infection**	Special attention must be given to: • Indigenous people with respiratory disease and respiratory infections • People with disabilities, including intellectual disabilities have special vulnerabilities to COVID and other respiratory infections. Dementia care: sufficient recognition is needed that some medications can increase risk of infection or worsen prognosis (for example psychotropic drugs for Behavioural and Psychological Symptoms of Dementia (BPSD). The assessment and management of dementia in the community remains a problem. At present neither level of government has assigned responsibility and therefore accountability. As a result, carers carry an unnecessary burden, Behavioural and Psychological Symptoms of Dementia (BPSD) and other co-morbidities are poorly managed, people with dementia living alone are neglected; and people are admitted to residential care	Draw attention to care risks associated with identifiable populations such as those with dementia, Indigenous people with respiratory disease[13] and others. Promote awareness that some medications have risks in a pandemic situation such as an increased risk of infection. Implement processes for the assessment and management of dementia in the community. Support for communication and community connections must not be overlooked for some patients, that because of their conditions, struggle with telehealth etc.

[12] Australia's National Digital Health Strategy - Safe, Seamless and Secure: evolving health and care to meet the needs of modern Australia.
[13] National Aboriginal Community Controlled Organisation 2020 Submission to the Australian Government's response to COVID- 19 https://www.naccho.org.au/wp-content/uploads/Submission-on-the-Australian-Governments-response-to-the-COVID-19-pandemic.pdf

	prematurely. In a pandemic situation these risks are heightened and counter options are limited. Telehealth can be very difficult for patients with dementia.	
Culturally and linguistically diverse (CALD) older persons	COVID-19 health information for CALD populations, needs to be issued early and through multiple channels. Some people in this category have poor health literacy which is a further disadvantage. Internet sources should not be relied upon. Note a large proportion of the aged care sector workforce come from CALD backgrounds, and their communication needs around training need to be taken into consideration.	Enhance safety by producing information for healthcare workers in other languages. Act quickly to develop and disseminate information for CALD groups through multiple channels, especially high-risk facilities.
Mental health care	We anticipate that post COVID mental health care will be needed. We draw important attention to older adults who withdraw from community contacts to reduce their risks. This is a mental hardship that involves not being able to support extended families, not being able to work, not participating in beneficial community organisations, etc for prolonged periods. [14] It is also important older persons are given accurate and timely information, for example about available services and supports.	The Department of Health to direct that key areas of need be identified within PHNs. Older people in the community need sources of mental health support and publicly available information on accessing this support through effective channels. Community responses offered could includer a helpline or other strategies, or other contact channels. Clear advice to older persons is essential about the extent of 'isolation' needed.
Protecting health care workers	Many caregivers and nurses work for more than one health care provider. This has inherent risks for infection transmission and must be recognised early.	. Every health care organisation must be advised that they must inform the health staff of the necessity to wear PPE and ensure they have received training before exposing patients to risk.

Frontline experience of Physicians: points of note

Further to the above issues, the RACP includes the following observations, adding to the points made in the above table:

> Once a response team/ taskforce was established in the areas of the outbreak, there were effective efforts being made, including multidisciplinary meetings held with families and residents, however none of these processes were being reported upon. This might have helped to share learnings.

[14] Wu B. Social isolation and loneliness among older adults in the context of COVID-19: a global challenge. Global Health Research and Policy. 2020 Dec;5(1):1-3.

There was significant negative public attitude towards the aged care sector with media coverage focusing on negative outcomes.

Physicians noted inequity of treatment and access to services between COVID-19 suspect/ positive patients and non-COVID-19 patients.

There was a notable reduction in hospital inpatient and outpatient attendance. This may be related to patients and families avoiding hospital and possibly also due to less falls and infections (from less socialising).

During COVID 19 France has established a multidisciplinary geriatric evaluation and coordination unit to promote local assistance and the organisation of care. It has downstream pathways including the resources for different levels of care and has included a specific COVID geriatric palliative care department. [15]

Concluding remarks to the Royal Commission

The RACP thanks the Royal Commission for their work on aged care and for this opportunity to describe the experience of physicians of many specialties both essential to the healthcare of older person and to the management of COVID-19. This experience forms the basis of our recommendations for improvement.

We have aimed to keep our submission in a format that makes clear the issues encountered by our members as frontline healthcare providers and how these issues might be addressed.

To this end we offer our continuing support to advise and collaborate in improving this healthcare sector.

[15] Koeberle S, Tannou T, Bouiller K, Becoulet N, Outrey J, Chirouze C, Aubry R. COVID 19 outbreak: organisation of a geriatric assessment and coordination unit. A French example. Age and Ageing. 2020 May 6.