
# Member Hearing Update 85 – Thursday 13 August

## Royal Commission Hearing: The response to COVID-19 in aged care and Accommodation

### Closing remarks by Mr Peter Rozen QC, Senior Counsel Assisting

Mr Rozen opened his closing remarks with the statement that the problems which bedevil the system have a profound effect on its users and COVID-19 has a profound effect on aged care. Following hearing the evidence Mr Rozen came to three key conclusions:

1. COVID-19 constitutes an unprecedented challenge.
2. Everyone involved has and is working very diligently to work to that challenge.
3. None of the problems was unforeseeable.

The risk is high even in low risk settings. The level of risk requires a level of preparedness that is very high. Not all that could be done was done.

What was needed was a planned and proportionate response to COVID-19. The sector was not given the opportunity to learn and consequently the sector is still not well prepared.
The federal government had been firmly put on notice on the challenges the sector would face with a COVID-19 outbreak through:

- The aged care workforce strategy report: A Matter of Care
- Lessons from the northern hemisphere
- The Royal Commission's interim report which raised issues of workforce, governance and the interface with the state sector
- Other experts and unions raised their concerns and offered solutions

In Mr Rozen's view the preparedness of the sector, aged care residents' quality of life and visitors to RACFs remain pressing issues.

In population health individual choices make way for the greater good. It is an important societal response to the pandemic. The rights of the COVID positive resident needs to be considered as well as the right of the COVID negative resident to remain negative. Workers need to be safeguarded.

Mr Rozen referred to Professor Spurrier's evidence that the precautionary principle in population health would cause one to err on side of caution. He noted that this principle is not enshrined in

the Aged Care Act.

Did the Commonwealth have a COVID-19 response plan for aged care?

Professor Murphy detailed expenditure but this was reactive rather than preparatory.

Professor Murphy further referred to the *The Australian Health Sector Emergency Response Plan for Novel Corona Virus (COVID-19)* but this plan does not focus specifically on aged care. The CDNA's *Coronavirus (COVID-19) guidelines for outbreaks in residential care facilities* is a guideline for an individual facility it is not a plan for the sector. It is based on the preparation for influenza and this would have given providers a false sense of preparedness.

Any aged care specific pandemic plan should include scenarios and identify triggers when infection control measures need to be stepped up. The plan should further identify practical solutions – this is what is being meant by a plan. It should address the interfaces with the number of agencies involved in an outbreak and the associated roles and responsibilities to avoid confusion. For example, who is responsible for hospital transfers needs to be addressed?

The roles of providers and different government agencies were not formalised until June and then most likely only in NSW. Such documents could easily have been prepared in February. State specific protocols are needed.

The aged care sector needs a bespoke plan which should identify and address:

- Gaps in the number and training of the workforce
- The availability and use of PPE
- PCW without a reliable foundational knowledge base
- Lack in clinical skills
- The particular challenges of infection control in a home like environment
- Governance issues
- Operational differences between hospital and residential aged care
- Interface with the health care system.

As the understanding of virus continues to evolve there is a need to adapt/discard plans that do not work. The concept of reasonable practicableness is not fixed in a pandemic.

It is important not to judge the knowledge gained by February 2020 based on what is known now, however, concerns were reasonably foreseeable.

The ACQSC submitted to the Royal Commission a plan that is based on the Braithwaite regulatory pyramid. It lacks a detailed planning approach that undertakes a gap analysis, identifies the profile of all RACFs and describes the practical tasks involved in preparation.

The ACQSC, when undertaking routine monitoring of providers and on learning about a new outbreak should have had systems in place to pass this information on to the DoH. Such a system was instituted only after the ACQSC failed to inform the DoH of a new outbreak for four days. Processes are now in place to ensure this does not happen again, but this is reactive and does not constitute planning ahead.

Mr Rozen proceeded to examine the preparedness put in place to support the sector across three time periods:

1. Feb – March with the first outbreak occurring in aged care

The opportunity to undertake the preparatory work to protect aged care residents is being missed by the federal government.

2. April – June

After the outbreaks in Dorothy Henderson Lodge and Newmarch House an opportunity existed to assess the state of planning and to augment plans were required. This was partially done by the introduction of case managers for COVID affected RACFs and the introduction of the surge workforce. But the Commonwealth did not share the learnings from the outbreaks with other providers to facilitate the updating of their preparations.

The pointy end of preparedness is equipping providers with the knowledge and help they need. Why did the Commonwealth not make systematic arrangements to provide access to infection control expertise which so essential in the first 24 hours of an outbreak? Even a well-managed provider needs the help of high level infection control expertise from day one of an outbreak. It is not enough to tell providers to get a nurse responder as per CDNA guidelines.

The advice in the CDNA guidelines to prepare for workforce losses of 20% to 30% lulled providers into a false sense of security.

3. June – August with the outbreak occurring in Melbourne

Masks are cheap and effective. But while daily rates for new infections are growing in June, masks for aged care workers are not made compulsory by the AHPPC until 13 July 2020. Professor Murphy and Mr Lye cannot explain the legal instrument for this direction. This level of confusion by senior officers at DoH is considered by Mr Rozen to be far from reassuring and looks to him like decision making on the run by press release.

Would earlier action have limited spread? Professor Murphy conceded this possibility in hindsight. But the DoH should have been alerts to the figures and give guidance to the sector as COVID-19 numbers grew. This reactive response demonstrates a lack of planning earlier in the year and the need for a dedicated national aged care response group.

A National COVID-19 Aged Care Plan could still be put in place by a coordinating body that includes expertise about the aged care sector, infection control and emergency preparedness and response and consumer advocates.

The National COVID-19 Aged Care Plan would need to consider workforce challenges, a relative lack of clinical skills, anticipate training and PPE use, the need for infection control expertise and what is required in an early outbreak response. It should include appropriate arrangements with other agencies such as the Clinical Excellence Commission in NSW so it is not left to chance that clinical expertise is available to a provider.

The challenges of casualised workforce and the financial strain put on providers while preparing for and dealing with the COVID-19 needs to be recognised. Many of these issues were raised in the Royal Commission's interim report and there is still time to put this information to good use.

Mr Rozen turned to the issue of how residents' quality of life can be maintained under COVID-19 conditions. All residents are legally entitled to quality of care, also in emergency times when this is even more important. Most residents have not had the experience of an outbreak but have experienced restrictions beyond that of the rest of the community. The virus is being kept out, but at what cost to the residents?

The role of informal carers to supplement care is critical for facilities with inadequate staffing. Many family members report deterioration of their loved one under lock-down conditions. Witnesses have called to continue to allow family visits, particularly of family members who continue to care for their loved-one. These informal carers can be educated in infection control to ensure they are safe visitors to the facility.

Julie Kelly, a registered psychologist who gave evidence spoke of the impact of the COVID-19 pandemic on the mental health of residents, their anxiety, loneliness, depression and deep sense of hopelessness that this may never end.

Next Mr Rozen turned to the visitation issue. Visitation is a contested issue which led to the Visitation Code, which however, is not binding. Providers are naturally anxious to limit the risk of an outbreak. There is no easy answers to strike the right balance but the long term nature of this pandemic needs to be taken into account. Initiatives such as a concierge service for visitors, walking programs, communication teams, training for families should be shared. Clearly such initiatives require resources and adequate staffing. However, even during times of community transmission a blanket ban on visitation is unacceptable in all but extreme cases.

Residents' access to allied health services has also been affected with their mental health and mobility deteriorating as a result, with long term ramifications. The Australian Government should consider immediate action on this front. The government reacted quickly to establish MBS items for mental health support for community dwelling citizens. Similar measures need to be urgently taken to support residents' mobility and mental health.

Mr Rozen finished his closing remarks by concluding that the sector is heading into an uncertain future. By now 220 deaths of COVID-19 occurred in residential care which are 70 per cent of all COVID-19 deaths, one of the worse rates globally. Australia's elderly deserve better.

The sector has been hindered in its response by a lack of coordinated planning by all levels of government. There is reason to think that a degree of hubris and self congratulation was displayed by the Australian Government, perhaps reflecting a general mood in the country that we were through it.

As late as 9 July 2020, Minister Colbeck wrote to providers saying that they 'responded incredibly well.' The letter urged continued vigilance but conveys no real sense of urgency. It contains no suggestion that providers should consider asking employees to wear masks.

By comparison, New Zealand has returned to an immediately lockdown after just a few cases were detected.  The New Zealand Aged Care Association Chief Executive Simon Wallace said in a media release that rest homes are not taking any chances. 'The experience in Melbourne where more than 100 rest homes have been affected shows the impact of not moving quickly.' Mr Rozen concludes at the end that perhaps the ultimate lesson is that we can't afford to take any risks at all.

Commissioner Pagone concluded this part of the hearing by commenting that the Royal Commission is trying to gain an understanding of the impact of COVID-19 on the sector while its effect is still underway. He observed that Mr Rozen made many helpful suggestions and urged the government to listen and appoint an aged care specific national coordinating body and to increase staff so more visits can be facilitated.

The virus does not wait and measures to effectively deal with the effect of pandemic on the aged care sector should not wait either.

**Sydney Hearing 3 - Accommodation**

**Counsel Assisting Mr Richard Knowles gave his opening statement to the hearings about Accommodation.**

Mr Knowles observed that most older people want to stay at home as they age but what is best depends on their circumstances. It is important that older people retain their autonomy and agency regardless where they live.

A general shortage of age friendly housing exists. An increasing number of older people experience housing insecurity. Older renters in the private market find it difficult to get necessary home modifications done. Older women emerge as a group unable to find secure housing without which they cannot access home care. Consequently they are required to move into residential care.

In the hearing on Friday 14 August, Mr Knowles plans to test seven draft propositions pertaining to:

1. The role of coordinated government planning
2. Incentives for age appropriate private accommodation
3. Increased funding for social and affordable housing
4. Liveable Housing Australia design guidelines
5. Grants programs
6. Dementia friendly design
7. The regulatory framework to include age friendly accommodation.

Three broad topics will be addressed:

1. The development of suitable accommodation
2. Social housing
3. Changes to the physical design of RACFs with a move away from the institutional design.

**Witnesses giving evidence were:**

**Maria Brenton, Senior Co-Housing Ambassador and Hedi Argent, direct experience witness, Older Women's Co-Housing (OWCH) with questions asked by Counsel Assisting Mr Richard Knowles**

OWCH is a group of 26 older women aged 51 to 91 years who are creating their own community under a positive living model, not care model. They consider their lives to be interdependent and mutually supportive ‘It is like living in a very small village where we know everyone and see to each other’s needs if necessary.’

Their housing complex Newground is entirely purpose built for older people with wider doorways, lifts, spacious bathrooms and lots of natural light. Of the women, 18 own their flat and 8 rent their flat from a small housing association with publicly subsidised rental assistance.

The development was made possible when a charitable trust offered a grant against which money could be borrowed. The complex was designed with input from the women. It has a Common House with a commercial sized kitchen for community meetings and other activities and a green space, including a vegetable garden which is tended by the community. The architectural design promotes the casual meeting of residents as they move about the complex.

The housing complex is administered by the women themselves via a number of committees, decisions are taken by consensus. It is the only co-housing community in the UK. The women

believe the reason for this to be ageism, where older people are seen as an object of care and paternalism. ‘They make us a problem rather than part of the community.’

The hearing closed 4.30pm

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