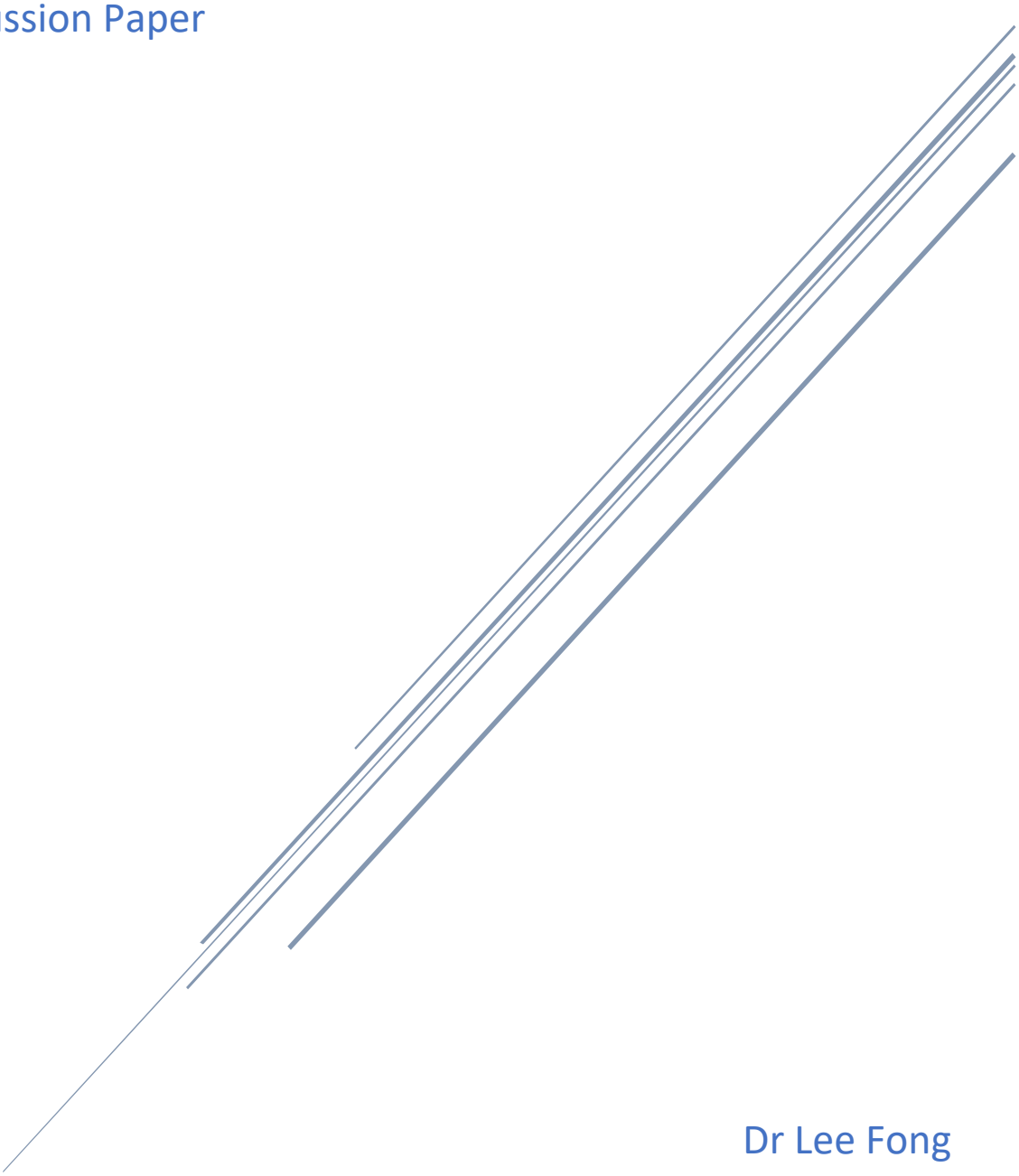
GP PERSPECTIVES ON RESIDENTIAL AGED CARE FACILITY COVID-19 PLANNING, PREPARATION & MANAGEMENT

A Discussion Paper



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Version 1, 4 September 2020

Table of Contents

1 Executive Summary

The accounts of beleaguered staff struggling with COVID-19 in residential aged care facilities (RACFs) overseas was first repeated in Australia at Dorothy Henderson Lodge, then Newmarch House, and now in over one hundred aged care facilities in Victoria.

WHO[1] described some of the problems underlying RACFs worldwide as follows:

- "*Long-term care services and health care systems are often poorly coordinated or integrated, and tend to have separate (and often complex) arrangement for financing, regulation, information systems and the training and procurement of staff.*"
- *"This has created several difficulties during the COVID-19 crisis. For example, back-up staffing models to meet the surge in COVID-19 patients in hospitals were not flexible enough to meet demand surges in the long-term care sector. It was also difficult for appropriate staff to move flexibly across the system as needed."*
- *"In addition, countries frequently distribute responsibility for long-term care vertically across national, regional and local actors, creating difficulties in coordination of services and effective oversight."*
- *"Before the COVID-19 pandemic, workforce shortages, poor pay and working conditions, and low proportions of professionally qualified staff were already a major concern…It is common for care workers to have zero-hour contracts and to work for multiple facilities or agencies."*

We have seen a lack of personal protective equipment (PPE) and appropriate infection prevention and control (IPC) training and assessment leaving staff unprepared for what was to come. The loss of up to 100% of regular staff has made a mockery of the RACF COVID-response plans that were dependent on those very same staff members. For some, it has turned a difficult situation into an impossible one.

In the midst of this, GPs have been left uncertain of their role. It was assumed by many that GPs would be able to continue telehealth services into COVID-affected RACFs, but in many facilities there was nobody who had the time to hold the iPad, even if they knew where it was or how to use it. It was realised that GPs were needed on the ground and in the facility, but under current MBS funding arrangements, trying to arrange this under COVID-related duress has been a severe challenge.

In the meantime, nobody in the RACFs had the time to answer the phone calls from the residents' families either, raising anxieties. Aged Care Planning completed in pre-COVID times was unhelpful in the face of this new, confronting paradigm – and so urgent, difficult conversations were needed with many resident families at exactly the worst possible time for them, adding to their distress.

Can we do better than this?

We can.[2]

Pre-outbreak, GPs can have an important role in increasing the resilience of RACFs, including their residents and families, by:

- Reviewing and participating in RACF outbreak planning and preparation, including:

[1] https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1
[2] https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/Sydney%20Hearing%202%20-%20Counsel%20Assisting%20written%20submissions%20-%2014%20August%202020_0.pdf

    - Reinforcing the need for repeated PPE/IPC training and drills
    - Encouraging zoning
    - Encouraging screening, using appropriate tools
    - Preparing documentation about RACF procedures and residents, assuming the loss of 100% of staff
    - Talking to residents and families about what to expect if COVID-19 enters the facility, and preparing them by exploring their goals of care
- Participating in the RACF outbreak management plan
    - Providing telehealth services, where this is still feasible
    - Providing face-to-face services, where this can be coordinated
    - Keeping families up-to-date with the status of their loved ones

To undertake these tasks safely and sustainably, however, requires coordination and support.

It is proposed that the Department of Health increase access to MBS items in COVID-19 affected RACFs, as well as allocate funds to PHNs nationally to coordinate regional RACF GP responses:

- Survey the RACFs in their region, including collating which GPs attend each RACF;
- Networking GPs attending RACFs into RACF-specific and regional RACF communities of practice;
- Determine if there is/are GP(s) at each RACF that would consider being the lead GP for communications at each RACF, and what supports would be needed for the role;
- Determine what services each RACF GP would consider continuing in the event of a COVID-19 outbreak, and what supports they would need to delivery these services (such as telehealth and face-to-face care);
- Determine if there was interest in the regional RACF GP community of practice to create a regional surge GP workforce, which could provide telehealth-based and/or face-to-face services;
- In discussion with funders (Department of Health, State Health) and local healthcare organisations (public hospitals, GP respiratory clinics, GP cooperatives, private hospitals, locum medical agencies), facilitate and provide the administrative and financial support their regional RACF GPs require to undertake roles that provide RACF GP services that are evaluated as being beneficial, viable, sustainable and safe

As is typically the case with primary care, the investment required to do the above would be relatively modest.[3] <u>The outcomes we are seeking are substantial</u>:

- through improved planning and preparation, to reduce the number of affected RACF residents
- through the direct provision of care, to preserve medical care to residents and reduce pressure on the public hospital system
- through well-defined processes, to protect and preserve clinical staff, including RACF staff and GPs
- through better communication, to reduce the distress experienced by affected RACF residents and their families

[3] [3] "*We incurred additional costs of approximately $2.4 million in managing the outbreak at DHL, with approximately $1.7 million relating to additional workforce costs…"* Royal Commission Submission by BaptistCare NSW&ACT (Dorothy Henderson Lodge)

2 Introduction

"*Victoria has been preparing for this 'second wave' since the absentee first wave...I guess we never knew if we were really ready until we were put to the test. Well now we know!! When the [dreaded] phone call came, that email arrived, or that result of a positive COVID19 showed up in our inbox, then, only then we realised how unprepared we were.*" Dr Bernard Shiu, GP, Geelong, Victoria

Overseas experience has demonstrated that the impact of COVID19 on Residential Aged Care Facilities (RACFs) can be catastrophic.

From the WHO report "*Preventing and managing COVID-19 across long-term care services*":[4]

- *"In many countries, evidence shows that more than 40% of COVID-19 related deaths have been linked to long-term care facilities, with figures being as high as 80% in some high-income countries"*
- "*The evidence…shows that once COVID-19 infection is present in long-term care facilities it is difficult to control, in part due to the large numbers of people living close together in facilities designed for communal living and the fact that personal care requires close proximity…*"
- "*There is increasing evidence of potential transmission from presymptomatic or asymptomatic people who have COVID-19 and people presenting with "atypical symptoms" in long-term care facilities. Studies of outbreaks show that 7% to 75% of residents and 50-100% of staff who tested positive are presymptomatic or asymptomatic.*"
- *"… residents of long-term care facilities are often facing higher risk, lower preventive measures and inadequate resources to manage COVID-19…"*

Earlier this year, Sydney experienced two RACF outbreaks, at Dorothy Henderson Lodge[5] and Newmarch House[6]. Commenting at the Royal Commission into Aged Care, Peter Rozen QC submitted that "*lessons of those two [Sydney RACF] outbreaks were not properly conveyed to the sector and as a result the sector was not properly prepared in June 2020 when we witnessed high levels of community transmission in Melbourne."*

As of mid-August 2020, more tragic lessons are being learnt by GPs on the frontline of the RACFs battling COVID-19 in Melbourne. To date, in Australia, 68% of deaths from COVID-19 have been residents of RACFs.[7] Furthermore, there is increasing concern about the transmission of COVID-19 to RACF healthcare workers.[8]

This discussion paper aims to:

- collate the experiences of RACF COVID-19 responses from a GP perspective
- providing scaffolding that will best support a safe and sustainable GP response
- provide options that assist the RACF sector better prepare for and manage COVID-19

[4] https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1
[5] https://www.health.gov.au/sites/default/files/documents/2020/08/review-of-dorothy-henderson-lodge-covid-19-outbreak.pdf, https://agedcare.royalcommission.gov.au/system/files/2020-08/RCD.9999.0379.0001.pdf
[6] https://www.health.gov.au/sites/default/files/documents/2020/08/newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf
[7] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers
[8] https://www.bmj.com/content/370/bmj.m3350

3 Background

3.1 Victorian & NSW RACF COVID-19 Response – Medical perspectives

"*No plan of operations reaches with any certainty beyond the first encounter with the enemy's main force.*"
Helmuth van Moltke, 19th century Prussian military commander

The information presented in this section has been collated from webinars involving Victorian GPs, geriatricians, infectious diseases physicians, hospital in-reach medical staff, and hospital COVID-19 inpatient unit medical staff, as organized by Dr Sachin Patel, Project ECHO (WVPHN), the Aged Care Emergency service (ACE, HNECCPHN), and the RACGP, as well as medical social media postings, personal conversations and personal correspondence.[9] Relevant extracts from the outbreak reviews at Dorothy Henderson Lodge and Newmarch House are included as footnotes.

3.1.1 Typical pattern of RACF outbreaks seen in Melbourne

- Typical pattern of disease transmission and loss of staff:
  - Day 1 – first COVID-19 case diagnosed and multiple staff members furloughed. If key members of command & control from the facility are lost to furlough, this can be a major contributor to the facility failing within the next one or two days. Multiple teams go in from multiple jurisdictions and start tripping over each other as they gather a huge amount of data, much of which is of peripheral benefit, other than key issues of staffing, staff safety, logistics and support to the facility;
  - Day 2 – PCR results of facility-wide testing – several staff and more patients are infected. Serious loss of staff confidence, resulting in loss of further 10-20% of staff;
  - Days 3-4 – loss of ~30-40% of staff, particularly but not exclusively around personal care, resulting in the RACF approaching crisis point as to whether the RACF can continue to safely provide care to on-site residents.[10] If crisis point is reached, transfer of patients may begin to private and public hospital, both in hours (controlled) and out of hours (uncontrolled);
  - Day 5 onwards – if facility remains operational, ~1/3 of facility residents are COVID positive. Public hospitals called in to be major partners, calling for volunteers from their own staffing pools, including reallocating directors of nursing. Many staff who have not been regular floor staff enter the facility, together with agency staff (increasingly difficult to find), and/or private hospital staff, and/or Australian Defense Forces (ADF). The RACF may be able to limp along at 1/3 to 1/4 of usual staffing levels; OR fail completely

[9] See Appendix 6, 7, 8, 9

[10] "*With increasing numbers of Newmarch House staff furloughed, families reported a corresponding concern about the diminished availability of staff familiar with the residents and their individual needs and preferences. In turn, feedback from families indicated that care delivery was compromised during this time, including delays in attending to the residents' regular care needs as well as omissions of care. They reported that this resulted in weight loss, dehydration, pressures sores, increases in urinary tract and skin infections and general deconditioning*." Newmarch House COVID-19 Outbreak Independent Review

- Workload for GPs has been extremely heavy – there are some notable examples where GPs have "thrown themselves into the fire", but the effort required is essentially unsustainable, with very few practices able to continue this beyond a few days.
- Cohorting has not been successful, for a wide variety of reasons

3.1.2 Planning & Preparation

- By far the biggest issue, dwarfing all other concerns, is that RACF care staffing is likely to be severely curtailed (e.g. 30-100%) in the event of an outbreak (furloughed as close or casual contacts, unable to work as a vulnerable worker, or unwilling to work)[11,12]. When much of pre-outbreak planning is based on the assumption that there will be enough care staff retained to be able to deliver safe care, cohort patients etc. – this is a tremendous concern.
    - RACF should have conventional plans to replace staff (e.g. accessing Mabel and/or other nursing agencies and/or HSA and/or Aspen and/or Rapid Response Group), but in Melbourne, these have been overwhelmed by demand from multiple simultaneous RACF outbreaks.[13]
    - If RACF remains viable, replacement staff may be:
        - unfamiliar with the residents
            - Patients need to have identification in the context of unfamiliar staff (e.g. arm bands)
        - unfamiliar with aged care (e.g. surgical staff from private hospitals)
            - Suggest RACF has a way to easily identify any remaining old staff – e.g. different coloured badge – so new staff can seek them out easily (otherwise almost impossible when wearing PPE) for information and advice
        - unfamiliar with patient care in any context (e.g. ADF members)
        - working at 1/3 to 1/4 of normal staffing level = no capacity to do anything beyond very basic patient care (at this point – cannot answer the phones, cannot check the faxes, cannot hold the iPad for telehealth)[14]

[11] "*At the start, many permanent staff did not return to work and those that did were, understandably, distress and afraid…*" Review of Dorothy Henderson Lodge COVID-19 Outbreak

[12] "*Staffing during the COVID-19 outbreak was severely depleted as a result of many staff being isolated due to COVID-19 infection or quarantined because of close contact. The requirements for staff replacements could not have been reasonably anticipated; they greatly exceeded the organisation's planned surge capacity.*" Newmarch House COVID-19 Outbreak Independent Review

[13] At Newmarch House, the experience with staff replacement was, "*In response to options offered by DoH, Anglicare chose to source replacement staff from Mable®. However, a high proportion of those put forward initially, was rejected by Newmarch House managers because of little or no past experience in aged care and/or IPAC training…The staffing situation reached its nadir on 20 April 2020 but slowly improved, with increasing numbers of nurses and carers provided by Mable®, Aspen, St Vincent's Hospital and up to eight other agencies. However, the skills and experience of staff provided by different agencies were highly variable and the numbers available unpredictable from day to day. Some staff were not aware that there was COVID-19 at Newmarch House and left soon after arriving for duty…In the third week of the outbreak when registered nurses from Aspen Medical arrived, they were expected to supervise IPAC but none was a credentialed IPAC professional.*" Newmarch House COVID-19 Outbreak Independent Review

[14] The experience at Newmarch: "*There were frequent reports of extensive delays in responding to inquiries from those seeking information or updates about their loved ones, as well as experiences where telephone calls, messages and emails simply went unanswered. These issues extended to support agencies and health professionals trying to*

- RACF GPs should work with the local PHN, regional health authorities (including infectious diseases, geriatricians, emergency departments), ambulance service and nearby GP clinics to increase understanding of roles and responsibilities before, during and after an outbreak
- Talk to the RACF manager about their outbreak preparation and response plan
    - Implement planning and strategies in place for each facility that have realistic and actionable goals.
    - Zone the facility if possible, even before an outbreak, e.g. Zone A, Zone B and Zone C
        - Assign staff and residents exclusively to each clearly marked zone. This limits the number of staff that need to be furloughed in the event of any outbreak
        - Following an outbreak, the Zones can be renamed (e.g. Red Zone is COVID-positive, Yellow Zone is COVID-suspected, Green Zone is COVID-negative)
- Diagnose early
    - Have a very low threshold for testing; with suspected cases, isolate residents with suspected COVID-19 as early as possible. Safer Care Victoria has released a very sensitive screening tool[15]
    - Have a clear plan for what you will do if the swab comes back positive
- Ask your facility to have the following information readily available and easily accessible for each resident:
    - Medical summary
    - Current medication list
        - current prescriptions (to be used in the event of a transfer to a private hospital)
        - palliative care medications charted *now* – in the middle of an outbreak, there will not be the staff or communication channels to get this arranged efficiently
    - Goals of Care/Advanced care plan (ACP)/up-to-date escalation plan
        - The biggest problem the hospital in-reach services have is lack of advanced care planning that is (a) COVID-19 specific, and (b) *with* the knowledge/understanding of the family – e.g. may have a comprehensive ACP for a patient, but family was unaware of this, then patient at transfer to hospital is *in extremis* and unable to participate in medical management discussions - this results in many distressing hours for the family
        - Cardiopulmonary Resuscitation (CPR) for COVID-19 RACF patient is both *futile* & *dangerous* and should not be offered (see 3.1.6)
        - Some ACPs are not done very well and need to be reviewed – e.g. done by RACF activity officer resident upon resident's arrival, not done with reference to their medical conditions or with an understanding of the terminology/process. Especially if utilised by care staff not familiar with aged care (e.g. reassigned surgical ward staff) this may result in attempts to do CPR with a high risk of adverse outcomes for the care staff involved
    - Resident identification - recent picture of the resident with the resident's name (if there are no regular staff left, nobody will be able to identify the patient)
    - Family contact details that are up to date
    - GP contact details that are up to date

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make contact with Newmarch House…At the peak of activity, senior managers reported receiving dozens of calls and texts every hour to their personal mobile phones, creating an impossible task to respond to these in a timely manner. The main switchboard also reportedly "crashed" under the call volume." Newmarch House COVID-19 Outbreak Independent Review

[15] This may need to be moderated depending on local testing criteria/local transmission rates. See Appendix 13

        - One page nursing care-plan
    - Consider what medical services will be available in the after-hours period (including weekends)
    - Consider how you will protect your family
        - Have a process at your home for managing PPE, soiled clothing/scrubs, self-isolating

3.1.3 PPE

- Always wear full PPE when visiting a facility – glove/gown/mask/eye protection – it protects the residents, excludes you from quarantine/close-contact definition if a resident in the facility subsequently tests positive.
- All staff in a Melbourne RACF should be wearing masks and face shields as an absolute minimum.
    - In a relatively unsophisticated workforce, face shields may help to protect staff from self-contamination by touching their facemask. Facemasks are hot & uncomfortable, and almost impossible to resist constant adjustment/touching.
    - A RN who has worked in COVID RACFs has reported that RACF care staff were repeatedly self-contaminating by touching their face despite training – they are not used to an infection control mindset and must have repeated observed training via a designated PPE mentor until it is second nature *before* an outbreak. She saw breaches occurring repeatedly despite the use of face shields. Consider having a PPE day every week to try and get staff used to wearing and using PPE correctly.
- Encourage your RACF to train and drill, train and drill, train and drill – *before* an outbreak occurs
- Removing PPE is a very high risk time for self-contamination. Make sure a doffing station is both present and appropriately set up. Always have a buddy and spot for each other. Practice, have instructions at each PPE station, TAKE YOUR TIME & DO IT SLOWLY. Have a clean PPE set to practice at home in front of a mirror. Instructional on-line videos can be useful as an educational tool.[16]
- If looking after patients with suspected COVID, use a N95 facemask
    - Make sure you have done appropriate training/fit testing and check fit every time you wear them
    - Shave off a beard to allow for a better N95 fit. If fit testing identifies you are not suitable, or you cannot tolerate a mask/eye protection, you can wear a ventilated hood (powered air-purifying respirator/PAPR) – it is not cheap (~$1300) but may provide a reassuring sense of security for the wearer. Be aware that it's use can cause angst amongst other staff who are wearing conventional PPE.
- Even with PPE, distancing yourself from patients is your most important protection
    - Why go into the room if you don't have to? – you can stand just in the doorway and shout if you need to
    - Avoid examining patients unless it will change your management
    - Avoid aerosol generating procedures – cease nebulisers and change to spacers wherever possible. Review CPAP and BiPAP, consider under what circumstances are they needed, consider calling the prescribing respiratory physician for advice.
- If you see a mistake during donning or doffing – call it out, but do it gently and be supportive – we are in this together

[16] For example, https://www.racgp.org.au/clinical-resources/covid-19-resources/infection-control/videos-using-ppe-and-hand-sanitising

- Consider attaching a photo of yourself onto the outside of your PPE so the resident can see who you are
- If a facility is struggling to meet infection control standards, typically the local health service will be able to assist. If further difficulties are encountered, escalation to the Aged Care Commission[17] can be helpful.
- When donned and doffed well with a buddy, PPE works. One in-reach doctor swabbed ~40 COVID19 RACF patients in one day, and as of day 13 post-contact, has remained well (wearing gown, gloves, N95 and face shield)

3.1.4 Outbreak management

- Note that the role of any one individual GP may vary tremendously in a hugely complex situation. In a RACF outbreak there will be multiple agencies involved to different extents depending on how stretched their resources are. This leaves GP involvement fluctuating anywhere from no involvement to unsustainable over-involvement.
    - The demands of COVID outbreak care are likely to be impossible for any one GP to independently resource in a sustainable way
    - Typical plan is that hospital in-reach managed COVID-related/more acute patient issues & GPs manage non-COVID-related/less acute patient issues (via telehealth)
    - It may take a couple of chaotic days[18] to address (or know if it is possible to address) (a) adequate staffing, (b) assurance of basic care of residents. After that, if the facility is still operational, some attention can be returned to routine primary care provision
    - As the outbreak transitions to resolution, more care is also transitioned back to the GP
    - Communication will be difficult and less than perfect – everybody will be experiencing anxiety and frustration
- As soon as a diagnosis is known, talk to the RACF and ensure they have
    - Implemented a strict infection control plan and isolation of residents pending further advice
    - A plan for facility-wide testing
    - That they have activated their outbreak management plan, including informing their local public health unit/in-reach service
- Isolation/cohorting can be very difficult, depending on
    - Remaining staff
    - RACF infrastructure
    - Wandering/confused residents

[17] https://www.agedcarequality.gov.au/

[18] The Newmarch experience: "*Anglicare managers…reported frustration about conflicting advice from different agencies and the lack of clarity about the hierarchy of authority…multiple changes in management roles, the absence of senior managers on-site and the paucity of information about resident status and failures of communication at Newmarch House engendered an impression of chaos and lack of control. Some of these issues were clarified by a COVID-19 Outbreak Management Plan, the third and final version of which was completed on 21 April 2020 but not before the confusion, lack of clarity about the hierarchy of authority, unstable internal leadership and inadequate human and physical resources had taken an enormous toll on Newmarch House residents, their families, staff and managers. The stress and tension among all stakeholders was aggravated by negative media attention and growing public alarm.*" Newmarch House COVID-19 Outbreak Independent Review

- The physical and psychological toll of isolation on residents is very significant[19]
- Monitor medical status carefully – elderly can progress from asymptomatic to very unwell rapidly
    - Ensure baseline observations are done daily
- Supporting staff
    - Nurses, GPs, allied health and admin staffs are doing their best. They are also human and have their emotional and physical limits, so be mindful of their needs
    - Nurses and doctors can become exhausted and fall ill[20] too. They also need to be looked after.[21]
- If you have concerns about the ability of facility being able to cope or manage safely, escalate immediately with your local in-reach service/PHU
    - As previously noted, by far the most common reason for failure is related to the inability of a RACF to provide basic care due to staff shortages
- The ability to provide care via Telehealth will degrade as staffing numbers fall – as mentione previously, there will be nobody left who has the time to answer a call or hold an iPad
- When local health services reach capacity, consider involving private geriatricians where they are accessible/available

3.1.5 Communication

- RACFs are frequently supported by agency nurses and a large number of visiting GPs, which predisposes towards major communication and commitment issues. When an outbreak occurs, the number of agencies involved multiplies. Mitigate communication risks in advance of an outbreak, as an existing communication issues will only get worse as 1000-2000 calls to the RACF can be expected in the first 24 hours
- GP to patient communication
    - Telehealth
        - Overcome RACF IT issues and willingness of RACFs to invest in the planning phase – get it ready to use pre-outbreak
        - Once it is operational, force yourself to use it pre-outbreak as much as you can (e.g. do every second RACF consultation by telehealth). It will be difficult and time-consuming to begin with, but in the event of an outbreak you will deeply grateful for the investment in time that you made.

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[19] "*…the absence of physical contact with loved ones and lack of exercise and fresh air seriously affected residents' mental and physical health. Some became depressed, withdrawn or physically deconditioned…The visiting general practitioner expressed the view that the effects of the prolonged confinement were as great a threat to residents' health and wellbeing as COVID-19. Balancing these opposing risks to residents is among the many major challenges in management of a COVID-19 outbreak…*" Review of Dorothy Henderson Lodge COVID-19 Outbreak

[20] https://www.dhhs.vic.gov.au/sites/default/files/documents/202008/2001628_COVID-19%20Protecting%20our%20healthcare%20workers_v9.pdf

[21] From the United Kingdom RACF COVID-19 experience: "*The first 48 hours after the infection is critical for motivation. Staff are scared and greatly impacted by the media, especially social media. A significant minority stated 'they did not sign up for this' and 'can easily get home care jobs for the same money around the corner', and without risking their family…Communication, constant reassurance and motivation by the leadership is vital. 5am phone calls to the homes, making sure each employee's name is known in the conversation, plus attendance on the floor seven days a week out of hours, bringing chocolates etc to add to the atmosphere.*" https://www.theweeklysource.com.au/real-lessons-from-the-uk-frontline/

        - Many residents have (or could have) their own phone/devices – collate details, so you can contact them directly without being dependent on (severely overstretched and/or telehealth untrained) replacement care staff; encourage families to obtain devices for capable residents pre-outbreak
- GP to GP
    - Some GPs have established regional networks based on a communications platforms such as Telegram or Whatsapp, allowing all connected GPs to disseminate information almost instantly, including the latest information and useful protocols
    - Consider appointing a GP clinical lead to co-ordinate communication between clinicians, RACF staff, state health services, and families. The contact details of the designated lead role needs to be communicated to the RACF.
- Facility to GP
    - Establish relationships with visiting GPs – actively involve them in detailed outbreak management planning
    - Establish a clinical lead/champion GP at each facility to co-ordinate communication between clinicians, RACF staff and other stakeholders.
    - Establish a dedicated phone number or alternate means of contact for GPs so they can functionally contact the facility despite the overwhelming number of other phone calls the RACF will be receiving. Do not rely on a generic RACF operator number that goes to a centralised call centre.
        - Consider a single communications channel (e.g. email or Whatsapp)
        - use the ISBAR format
        - accompany requests for clinical review with a copy of the medication chart
    - Be aware that affected RACFs have had fax machines piled high with unread faxes, and telephones ringing unanswered. These are both the consequence of skeleton care staff prioritising direct patient care over reading faxes and taking telephone calls.
- GP to family
    - Even if an ACP already exists, hold advanced care planning and frank discussion with families before an outbreak to align expectations and possible outcomes
        - Warn them that the patient may be moved out of their usual room (if they have a hard-wire telephone in that room, this is another reason to obtain a mobile device for them and to make sure they know how to use it)
        - If you can contact family ASAP after an outbreak is known, that is hugely reassuring for the family
        - Explain it is likely that hospitals will not have capacity to take all patients in the context of a COVID outbreak
        - For those who are not for CPR/intubation, and particularly with dementia, most of the treatments likely to be offered in hospital can be offered at the RACF (assuming no other concurrent medical issues)
        - The alternative to NOT preparing families from “white” (non-COVID affected) facilities is letting them get their briefing from the media – which is disastrous, and leaves families with the expectation that all RACF residents who get COVID will go to hospital *and* get a ventilator
        - Combined messaging from GP and hospital in-reach is helpful
    - Maintain regular family communication during a COVID outbreak, either in bulk through email or SMS, and/or through direct phone calls and/or group video conferences, held at the same time (e.g. 4pm every day)

        - Most families want GP to provide ongoing care regardless of the other services involved. For this to be effective, the GP needs to be kept informed of the resident's clinical status.
        - During group zoom meetings there will be emotive moments – but by the end of it, families are grateful
    - If patients deteriorate despite oxygen, subcutaneous fluids and dexamethasone, then they will likely be for palliative care. Explain that going to hospital is generally not going to change this
    - IV fluids and IV antibiotics won't necessarily be appropriate in some patients with dementia who may pull out cannulas out, as well as remove nasal prong oxygen.
    - Residents may get delirium in hospital due to the change in environment
    - Get a feel for who will really want their family member to go to hospital regardless of the above, and who would prefer to stay. Warn them that it is possible that residents who want to go to hospital will not be able to, and that residents who do not want to go to hospital will have to.
    - Anticipate that 20% of families will have particularly high levels of anxiety – if you can identify who they are, be particularly pro-active with obtaining their contact details and ensuring they receive RACF updates/communications
    - Ensure anticipatory end of life medications are charted for all residents if there is a COVID outbreak in the RACF (or prior to one)
    - Consider the need for bereavement support – COVID-19 is setting people up for dysfunctional grief in the context of being unable to be loved ones at the time of death. Connect with local palliative care services to assist with this.

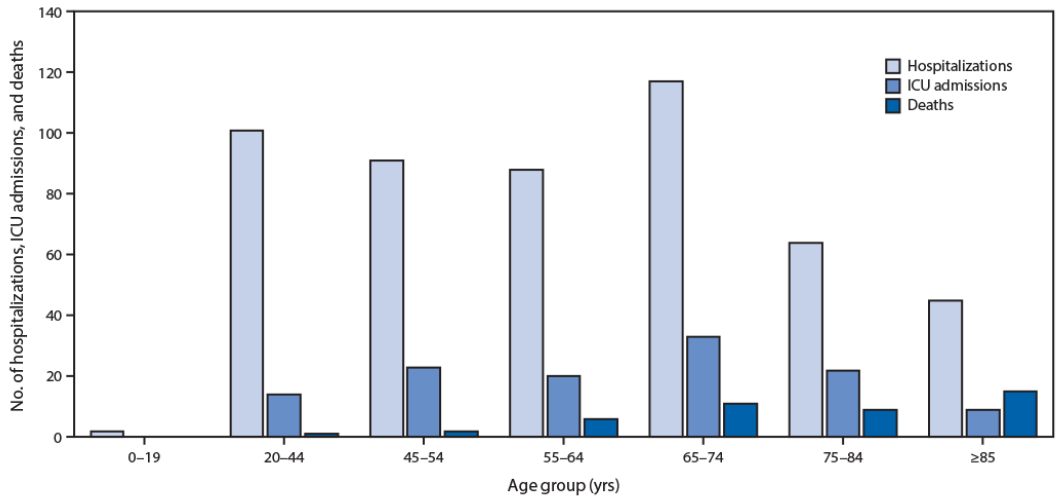
3.1.6 COVID-specific Advanced Care Planning

- Background information
    - "*The challenge: There have been reports that residents of long-term facilities have not been able to access healthcare in hospitals…It has also been reported that advance care directive have sometimes been put in place without adhering to the usual person-centred standards…Residents of long-term facilities have sometimes been denied hospital care based on irrelevant or discriminatory criteria, such as age, under the presumption that they are too frail to survive…Countries have responded by emphasizing the importance of equitable access to health and palliative care for older adults and people with existing conditions during the COVID-19 pandemic.*" "Preventing and managing COVID-19 across long-term care services", World Health Organisation
    - Cardiac arrest and CPR
        - Typically cardiac arrest
            - Affects 1-10 per 1000 hospital admissions
            - 80% have non-shockable rhythms
            - 15% of all patients will make it to discharge
        - BUT if from RACF, 0% with in-hospital cardiac arrest will survive to discharge[22]
        - CPR is aerosolising -> healthcare providers must be protected to care not just for the patient at hand, but also all the patients that will follow

[22] https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16270

- Natural history of COVID-19
    - Stage I
        - Early infection - 7-10 days viral replication – flu, cough, myalgia, loss of taste
    - Stage II
        - Pulmonary phase – abrupt deterioration; look fine at 5pm ward round, then MET call overnight, intubated/ICU
    - Stage III
        - Hyperinflammatory phase – multiple system failure, but predominantly ARDS (COVID lung -> bacterial superinfection)
- Predictors of mortality
    - Predictors of severe disease/mortality on hospital admission are Age >65, cardiovascular disease, cancer, CKD, hypertension, diabetes, chronic lung disease -> typically, frail[23] RACF residents have several of these
    - The older the resident, the worse the outcome
    - Survival rates if requiring intubation/ventilation are poor

FIGURE 2. Coronavirus disease 2019 (COVID-19) hospitalizations,* intensive care unit (ICU) admissions,† and deaths,§ by age group — United States, February 12– March 16, 2020



* Hospitalization status missing or unknown for 1,514 cases.

† ICU status missing or unknown for 2,253 cases.

§ Illness outcome or death missing or unknown for 2,001 cases.

(https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm#F1_down)

- In the above context, the majority of RACF patients with COVID-19 are unlikely to experience a survival benefit from intubation/ICU admission.

- What can be done?[24]
    - There is no cure
    - Oxygen for hypoxia
    - Antibiotics (e.g. oral Augmentin Duo Forte, IMI ceftriaxone) for Community Acquired Pneumonia

[23] Consider using the Clinical Frailty Scale to support advanced care planning conversations. Even without COVID-19, some RACF residents may have poor outcomes with hospitalisation. It has been suggested that those with a CFS of 5 or more are less likely to benefit from critical care (https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes)

[24] See https://covid19evidence.net.au/#clinical-flowcharts for updated clinical guidelines

- Subcutaneous fluids
- Drugs of benefit – including in RACFs
    - Dexamethasone – can be given in community for those needing O2, with demonstrated reduction in COVID-19 mortality at 28 days. Best efficacy in acute inflammatory stage, after day 7. Even from a symptom perspective, even 6mg can be highly effective. BUT does reverse sleep-wake cycle – so best to give in the morning.
        - GI bleed is possible, so consider cover with a PPE (NB no evidence for this)
        - No difference between IV or oral
        - UK – 6mg in trial because that is their vial size -> in Australia we have 8mg vials but staying with that 6mg (typically oral) dose, including in elderly. 6-10 day course, in elderly going with 6 days.
    - In hospital using DVT level prophylaxis – probably reasonable in RACF for normally mobile patients on oxygen
    - Remdesivir – reduction in length of stay for hospitalised hypoxic patients, no proven benefit in intubated patients; not being used in RACFs in Melbourne; extremely short supply (from National Stockpile),
- Palliative care - including in RACFs
    - symptoms can be treated effectively, providing both comfort and dignity

- Consider:
    - What are the goals of care for the patient?
    - Risk vs benefits of resuscitation
    - Note that ultimately medical staff define the ceiling of care – as much as we involve patients/family in the discussion. Functionally, patient choices are limited to those below that threshold.
    - Reasons for transfer to hospital in COVID times
        - Inadequate staffing -> basic care needs cannot be met – will be consistency issues with this as this is worked through
        - Acute deterioration in a patient who is appropriate for escalation for care – this is not necessarily COVID-related – e.g. falls, pressure sores. In Melbourne, COVID positive patients with mild or no symptoms will not be admitted.
        - Infection control – including staff concern – e.g. wandering, aggressive COVID positive patient. In this situation patients will be sedated – this would not be done in usual circumstances, but these are unusual circumstances and both staff and other patients need to be protected
        - *Public health – early on it was believed that removing the first one or two infected people from the RACF would prevent protect the rest of the residents/staff. This is not working out nearly as well as it was hoped. This is because by the time there is one diagnosed case, there are typically many undiagnosed cases already present. The new paradigm is that if you have one infected patient, you should assume that many others are infected (THIS DOES NOT APPLY TO AN INFECTED STAFF MEMBER). There are occasional exceptions to this – e.g. one case of a respite patient who was symptomatic very early on, and in one or two instances, early transfer of an index case seems to have made a difference – but these are exceptions.*

- Communication tips
  - Disclose the diagnosis and acknowledge the distress
    - Acknowledge the challenging time, sadness, distance, lack of control – and the sensationalist media
    - Listen to and talk through concerns
  - Discuss – what are the interventions that can be offered?
    - What would the hospital do? What can be done at the facility?
    - Oxygen, subcutaneous fluids and Dexamethasone can be given in the RACF; typically an admitted RACF patient will receive no more than that
      - Hospital admission will typically make no difference to outcome
    - For most RACF patients, it is not in the best interests of a RACF patient to have care escalated to intubation/ICU/full resuscitation.
  - The majority of families respond to clear, consistent messaging – be specific - if they know what to expect, they will not be as distressed when it happens.
    - What families don't like is a lack of information – that is distressing in itself, and then the distress only increases as their loved one deteriorates
    - Families are typically grateful for any information, even if it does not sound good (e.g. no CPR, no intubation, no ventilation)
  - Be mindful about access and place of death
    - Hospitals are not pleasant places to die – unfamiliar, bright, noisy, no visitors (RACF may be more flexible), everyone looking the same because they are covered in PPE
  - Acknowledge that the best laid plans are dependent on the nursing home being able to deliver the care proposed
  - "the difference between optimal vs what is possible"; "difficult decisions in abnormal times"; "no good choices - just the least worst"
  - Everybody on the ground is doing their best. RACF nursing staff are terrified, but still coming to work for the sake of the residents
  - Document meticulously
- For help/advice – talk to
  - A colleague
  - Residential in-reach service
  - Phone call to local hospital COVID unit
  - Consider courses in communication/difficult discussions

3.1.7 Facility re-establishment/repatriation of residents

- Before the transfer back (consider concierge service to make sure this happens):
  - Must make sure strengthening of PPE availability and training happens
  - GP availability established & ready
  - Staffing level is adequate
  - Adequate handover of care provided – tends to be easier from public hospitals, harder from private hospitals
  - Simple things:
    - Has PPE been restocked (or not, because the person who usually does it is furloughed)?

        - Has any the broken equipment (e.g. oven) been fixed?
        - Has food been ordered?
        - Has the rubbish been removed?
    - This process has not been clearly defined in Melbourne at the time of writing -> frustration. Hopefully better defined by week beginning 17/8/20

3.2 International RACF experience[25]

3.2.1 Systemic issues

- *"Long-term care services and health care systems are often poorly coordinated or integrated, and tend to have separate (and often complete) arrangement for financing, regulation, information systems and the training and procurement of staff…This has created several difficulties during the COVID-19 crisis. For example, back-up staffing models to meet the surge in COVID-19 patients in hospitals were not flexible enough to meet demand surges in the long-term care sector. It was also difficult for appropriate staff to move flexibly across the system as needed…In addition, countries frequently distribute responsibility for long-term care vertically across national, regional and local actors, creating difficulties in coordination of services and effective oversight."* [26]
- Pre-pandemic, nursing home are chronically short-staffed
    - Nursing-home staff make little money and work multiple jobs
    - Increased financial pressures to work while ill due to poor working conditions, such as lack of compensation for sick leave
- The above factors combine to create "…*environments with minimal resilience to adverse events*".[27]

3.2.2 Planning and Preparation

- One of the strongest correlates of whether nursing homes experience outbreaks is whether the surrounding community has local transmission of COVID-19
- Limits on visitation were not imposed early enough
- Lack of PPE
- Lack of training on IPC measures
- Lack of mechanisms to ensure implementation/monitoring/assessment of IPC guidelines

3.2.3 Outbreak Management

- There is a lack of suspicion re: symptoms, resulting in delayed testing and diagnosis
- Lack of blanket testing in affected RACFs promotes asymptomatic spread of COVID-19
- Physical distancing is difficult to achieve
- Initial success in Hong Kong with limiting COVID-19 transmission in RACFs by transferring COVID-positive patients to public hospitals was not sustained during the "third wave" in July 2020

[25] Appendix 10
[26] https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1
[27] https://www.researchgate.net/publication/342873693_Nursing_Homes_and_Long_Term_Care_After_COVID-19_A_New_ERA

        - "*Almost 90% of Covid-19 deaths in Hong Kong happened in the past month as the outbreak entered nursing and elderly care homes -- 48 deaths as of Monday, seven times the toll of the entire first half of the year.*" [28] 11th August 2020
        - "*Around 20 care homes, including those for the elderly and the disabled, have reported Covid-19 infections. Four homes accounted for 17 deaths, including nine linked to the Kong Tai Care for the Aged Centre Limited in Tsz Wan Shan and six from Cornwall Elderly's Home (Golden Branch) in Tuen Mun. Deaths from elderly care homes made up more than a third of all Covid-19 deaths so far*".[29] 9th August 2020
        - Hospital Authority chief executive Dr Tony Ko Pat-sing wrote on 17th July 2020 that hospital officials were "very worried" about the latest wave of infections. "*While there are quite a lot of community outbreaks that cannot be traced, our isolation facilities will soon be full*"
    - High staff turnover impedes continuity of care and consistency of IPC measures
    - Smaller companies have larger volunteer workforces and less capacity to surge workforce
    - Difficulty with obtaining surge workforce: "'*you can't get staff and you can't share staff'… External nurses also refused to attend, resulting in residents missing medications such as insulin. Agency staff refused to work in infected homes."*
    - Difficulty with management of non-COVID issues: "*The lack of hospital beds mean that residents who had advanced UTIs and falls were deemed to be unsuitable for admission by paramedics – leaving them in the home."*
    - Many residents of long-term care facilities have struggled with not being able to socialise with fellow residents, to participate in regular social activities, or to receive visits from their family and friends
    - Communication channels stressed: "*The phones were 'inundated'*.'
    - Family distress: *"80% of families are okay and 20% are 'beyond scared and extremely worried'"*
    - Long-term care workers experience substantial pressure on their mental health during the COVID-19 pandemic
    - Discharging patients occurring from hospitals with COVID-19 to RACFs for convalescence
    - Financial stress: "*A significant number of providers will run out of cash in the next two to three months."* (UK)

4 Discussion

The characteristics of SARS-CoV-2 include transmission by pre-symptomatic and asymptomatic patients, increased transmission in enclosed spaces,[30] and a high mortality rate in the elderly.[31] Even without "*…serious substandard care and unsafe practice, an underpaid, undervalued and insufficiently trained*

[28] https://www.bloombergquint.com/onweb/hong-kong-sees-fewest-virus-cases-since-start-of-latest-outbreak
[29] https://www.msn.com/en-sg/news/world/more-elderly-people-will-die-grim-facts-behind-hong-kong-s-covid-19-death-surge/ar-BB17JZiy
[30] https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions
[31] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

workforce…"[32], the infiltration by SARS-CoV-2 into Residential Aged Care Facilities creates a "perfect storm" that puts residents, families and healthcare workers at significant risk of distress and death.

Some systemic issues, such as a large proportion of the aged care workforce being casual and low-paid, driving some to continue working despite being symptomatic, and/or to work in multiple facilities,[33] are beyond the scope of this document. Measures to address these problems both in the short and longer term need to be enacted at a state or federal level.[34]

It is however, important to acknowledge these issues, as they are part of the limitations of the environment within which a primary care response must operate.

4.1 GPs and RACFs – Barriers to Involvement

The medical workforce best equipped to look after the primary care needs of RACF residents are their own GPs. The medical workforce best equipped to be involved in advanced care and palliative care discussions with RACF residents and their families are also their own GPs. What we have seen in the RACF COVID-19 response so far, however, has been a general underinvestment in stakeholder engagement re: COVID-19 planning and preparation involving RACF GPs, and instead a reactive approach that relies on tremendously expensive and finitely resourced state-based acute hospital and federally-contracted medical services – the proverbial ambulances-at-the-bottom-of-the-cliff.

A key role for GPs is the planning and preparation for an outbreak, anticipatory medications, chronic disease plans, conversations with families (including goals of care/advanced care planning), and contributing to the RACF outbreak management plan. Ideally, with good prevention, planning and preparation, an outbreak may be prevented or curtailed.

However, in as much as there are concerns that the RACF sector is marginally funded, resulting in suboptimal levels of care, there are pre-existing concerns regarding GP services being provided to RACFs. Even in the pre-COVID era, many RACFs have reported difficulty accessing GPs (54%), and some report this can lead to compromised care (15%). In addition there is a low GP participation rate, high and increasing use of acute care services, and concerns raised about the quality of the services provided.[35] The low participation rate is likely related to inadequate Medicare funding, the difficulty with fitting RACF services into a GP working day, high out of hours RACF demands, and a heavy component of unremunerated work (e.g. updating clinical records, generating prescriptions, completing medication charts, consulting with RACF staff, discussion with family members).[36]

Furthermore, the reduced employment of RACF RNs, the increased casualisation of the RACF workforce, and a growing trend towards RACFs using medical deputising services[37] undermines the relationship between GPs and the RACFs they attend.

[32] https://agedcare.royalcommission.gov.au/news-and-media/royal-commission-aged-care-quality-and-safety-interim-report-released

[33] https://www.ausdoc.com.au/opinion/were-all-blame-aged-cares-coronavirus-tragedy

[34] It is noted that there has been some positive movement in this area, such as Fair Work Commission's paid pandemic leave to staff working in residential aged care under the Aged Care Award, the Nurses Award and the Health Professionals Award (https://www.abc.net.au/news/2020-07-27/aged-care-workers-get-paid-pandemic-leave-fair-work-commission/12496342)

[35] https://www.racgp.org.au/afp/2015/april/models-of-general-practitioner-services-in-residential-aged-care-facilities/

[36] http://www.ruralhealth.org.au/15nrhc/sites/default/files/E1-4_Sefton%2C%20Battye.pdf

[37] http://www.ruralhealth.org.au/15nrhc/sites/default/files/E1-4_Sefton%2C%20Battye.pdf

In other words – there are already substantial challenges with the provision of GP services to RACFs in the absence of COVID-19. With the additional stressor of COVID-19, the difficulties to surmount are considerable, and will largely rely on the goodwill of participating GPs.

4.2 Options for GP Involvement

4.2.1 Pre-Outbreak: RACF Planning and Preparation

GPs could contribute substantially to planning and preparation at the RACFs they attend, particularly with regard to IPC.[38] Some RACFs are substantively engaging their GPs in outbreak planning, but, anecdotally, most are not. PHNs could have a significant role in helping to foster and facilitate increased RACF and GP interaction.

4.2.2 Pre- and Post-Outbreak: Communication with Families

The value of GPs communicating with families/relatives has been noted repeatedly. This is a time-intensive but essential way to facilitate the most appropriate care for individual residents, as well as to help minimise the experienced distress of both residents and their families. [39]

From evidence being presented at the Royal Commission into Aged Care, this is an issue of great concern that, with their existing relationships with RACF patients and their families, GPs can effectively address.

For this to occur effectively and efficiently, however, appropriate supports must be in place[40] (most obviously from the relevant PHN – see section 4.4), including:

- Prior to an outbreak
    - Developing a clear understanding of local public health service plans for managing RACF outbreaks, including triggers for escalation of care and resident transfers[41]

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[38] "*…there is wide variation in resident profiles, physical facilities, resources and access to expert professional support, between aged care organisations. In addition to implementing Commonwealth and jurisdictional guidelines, for prevention and management of COVID-19 outbreaks, consideration might be given, if it has not been already, to…engaging a general practitioner or specialist physician, with experience in IPC and infectious diseases to assist in outbreak planning and implementation*." Review of Dorothy Henderson Lodge COVID-19 Outbreak

[39] "*Family experience varied throughout the period of the outbreak and whilst there was positive recognition of the tireless efforts of staff, families expressed concerns about poor quality of care of their loved ones. There were numerous unsatisfactory experiences and instances of missed or delayed care resulting in adverse outcomes for some residents, in addition to prolific issues around communication.. Family members felt disempowered, helpless and let down as they found it difficult to make contact with the home for information about the health and welfare of their loved ones."* Newmarch House COVID-19 Outbreak Independent Review

[40] The Newmarch experience demonstrated how complicated this can be in practice: "*The role of nominated contact person was often changed by families because of the burden on one person of receiving information and having to pass it on to other family members. This was further complicated in families whose members did not ordinarily communicate with each other or in which there were existing or historical tensions. Delayed passage of information to a family member who was not the nominated contact person often meant that it was shared in the media before other family members were aware of it. In turn, this added to the frustration of family members already unable to access timely information about their loved ones.*" Newmarch House COVID-19 Outbreak Independent Review

[41] The Newmarch experience showed that this was not always clear: "*During the first two weeks of the outbreak, the VACS (virtual aged care service) team convened case conferences with residents, their nominated representatives and the resident's general practitioner, if available. The purpose was to explain the HITH program, review residents' advanced care directives and record their wishes for end-of-life care. Most residents and/or their representatives indicated that the resident would prefer to remain at Newmarch House if they contracted COVID-19. However, many relatives later felt they had not been given enough information to make a genuine choice. A general practitioner told the review '… I did question that. I said, "So we are not giving them a choice?" And they said, "No, but we will be providing everything except ventilation." On the other hand, a VACS specialist reported 'The majority of them told us that they want their family members to be treated in the nursing home, provided we can give them oxygen, IV fluids and … we*

    - Support to organise and conduct pre-outbreak meetings with residents and/or their families
- In the event of an outbreak
    - mechanisms for keeping GPs informed about the clinical status of their residents
    - support to organise and conduct regular meetings with residents and/or their families

This is probably one of the greatest contributions GPs can make in responding to COVID-19 in RACFs.

4.2.3 Post-Outbreak: Care Provision/Medical Services

In a RACF unaffected by COVID-19, medical services are provided by GPs. Once COVID-19 has entered a facility, supported by current MBS rebates alone,[42] it is unlikely that many GPs would be able to provide face-to-face services. The other main agencies that would be able to provide medical staff are state health and locum medical agencies. How GPs will deliver services in conjunction with these other agencies will vary depending on multiple factors. This can be considered in the context of the severity of the outbreak at a RACF:

- Low intensity RACF outbreak
    - Characteristics
        - Low community transmission
        - Few residents affected
        - RACF well prepared
        - Low proportion of care staff furloughed
        - Basic care needs can be met
        - COVID-19 transmission risk is assessed as being low
        - Most or all residents remain in-situ
        - Few regional RACFs affected
            - Public health services (e.g. public health unit, hospital in-reach) well within capacity
            - Surge nursing staffing services (e.g. Mable) well within capacity
        - Few RACFs nationally affected
            - Surge medical staffing services (e.g. HCA, Aspen Medical) well within capacity
    - Possible scenarios
        - Medical services completely assumed by hospital in-reach and/or medical locum workforce services
            - GP services are not required and/or not requested
        - COVID-related/acute medical care assumed by hospital in-reach services
            - RACF staff can support telehealth provision
            - GPs continue to provide non-COVID-related/sub-acute services, primarily via telehealth

- Medium intensity RACF outbreaks
    - Characteristics
        - Increasing community transmission
        - Increasing proportion of residents affected

said if they really needed to come to hospital we'll bring them to the hospital." Newmarch House COVID-19 Outbreak Independent Review

[42] Which may not even be able to be accessed for COVID-positive residents "admitted" under Hospital In The Home-type programs

- RACF not as well prepared
- Higher proportion of care staff furloughed
- Ability of RACF to meet basic care needs is marginal
- COVID-19 transmission risk is assessed as increasing
- Some residents remain in-situ
- Increasing number of regional RACFs affected
    - Public health services (e.g. public health unit, hospital in-reach) capacity is stretched
    - Surge nursing staffing services (e.g. Mable) is stretched or exceeded
- Increasing number of RACFs nationally affected
    - Surge medical staffing services (e.g. HSA, Aspen Medical) are stretched or exceeded

▪ Possible scenarios

- Public health services surge medical workforce into hospital in-reach
    - GP services are not required and/or not requested, or
    - GP input is facilitated by the use of remote case conferencing with on-site medical staff
- Public health services surge medical workforce into hospital in-reach, but unable to meet all medical needs
    - RACF staff cannot support telehealth service provision
    - GPs provide non-COVID-related/sub-acute services in RACFs via face-to-face consultations

○ High intensity RACF outbreaks

▪ Characteristics

- High levels of community transmission
- High proportion of residents affected
- RACF not well prepared
- Majority/all of care staff furloughed
- RACF is unable to meet basic care needs of residents
- COVID-19 transmission risk is assessed as high
- Residents are unable to remain in-situ = active transferring of residents to public hospitals, other designated COVID-19 facilities, and/or private hospitals
- Increasing number of regional RACFs affected
    - Public health services (e.g. public health unit, hospital in-reach) capacity is exceeded
    - Surge nursing staffing services (e.g. Mable) is exceeded
- Increasing number of RACFs nationally affected
    - Surge medical staffing services (e.g. HSA, Aspen Medical) is exceeded

▪ Possible scenarios

- Medical services receiving public/private facilities are met by public health staff (i.e. residents, registrars)
    - GP services are not required, or
    - GP input is facilitated by the use of remote case conferencing with on-site medical staff

- Medical services in receiving public/private facilities are not met by public health staff (i.e. residents, registrars), but public/private health services cannot expedite recruitment of GPs
    - Limited GP services can be utilised in private hospitals
        - Provision of private prescriptions for residents in private hospitals (non-MBS rebatable)
        - Telehealth services cannot be utilised
        - Face-to-face services cannot be utilised
- Medical services in receiving public/private facilities are unable to be adequately provided, and public/private facilities are able to expedite recruitment of GPs
    - GP services can be utilised in public/private facilities
        - Telehealth services
        - Face-to-face services

4.3 Mechanisms for GP care provision: Telehealth, Case Conferences, and Face-to-face care

Utilising GP telehealth services to provide RACF medical services has several favourable features:

- Presents the lowest personal risk to participating GPs
- With the assistance of the local PHN to establish a local RACF GP community of practice and administrative support, it could be a way to co-ordinate a localised and sustainable response. This was the model utilised at Newmarch.[43]
- Provides a mechanism for retired GPs to safely contribute to a medical surge workforce
- By excluding non-clinical activities (e.g. travel, donning/doffing PPE) telehealth services are easier to schedule into GP workflow
- There are MBS item numbers for telehealth services
- If the local PHN assisted with the creation of a regional RACF GP community of practice, GPs from other (unaffected) RACFs could potentially provide telehealth surge workforce capacity to affected RACFs – but note that restrictions re: the "usual GP" may prevent access to MBS rebates for this

However, telehealth is dependent on both the RACF infrastructure and staffing to enable it. Feedback from a Victorian geriatrician involved in the RACF COVID-19 response (and mirrored at Newmarch) is that the GP telehealth option has very significant limitations. In a drastically under-staffed RACF there is nobody who (a) has the time to take the call to be asked to hold the iPad for the resident, or (b) even if they can answer the call, does not have the time to actually hold the Pad. To that, we could add that if there are few or no original staff left in the RACF, quite probably (c) nobody knows where the iPad is or how to use it.

This has been the experience at Newmarch, where, despite the establishment of a 24/7 (presumably telehealth) on-call GP roster by the local PHN, "*It was soon recognised that on-site general practitioners would be required but it took some time before locum medical staff could be recruited.*"[44]

In the absence of the ability to support telehealth GP services, and in the absence of an on-site GP, and especially in the absence of many/any original RACF staff, the knowledge of the usual treating GP could still

[43] *"Local general practitioners had an important but probably under-utilised role in the early weeks of the outbreak… several assisted in case conferences with residents and relatives and volunteered for a 24 hour/seven day on-call roster organised by the local Primary Health Network. They provided valuable support to Newmarch House staff and residents, during the first two weeks of the outbreak, particularly for COVID-19 negative residents who were not admitted to HITH or monitored by VACS [virtual aged care service]. However, they relied on already busy nursing staff to contact them and some, who endeavoured to contact Newmarch House seeking information for anxious relatives, reported that their calls were often unanswered."* Newmarch House COVID-19 Outbreak Independent Review

[44] Newmarch House COVID-19 Outbreak Independent Review

be leveraged by on-site medical staff (e.g. from the local public hospital or a local agency). They could initiate case conferences with the usual GP to rapidly gain information which might have otherwise taken an extended period of time to uncover from notes and/or relatives. To facilitate this, however, there needs to be increased access to MBS case conference item numbers 735 – 758, [45] and an assurance that MBS items can still be accessed for residents under the care of Hospital In The Home (HiTH) services. (see 4.4.3).

Face-to-face GP services, in the event of RACF outbreaks of moderate to severe intensity would be the hardest to support. Even for ostensibly COVID-negative residents, this is higher risk for GPs, likely to be much more time-intensive, and would frequently require the cancelling of their other duties, including normal GP services. Options for delivery of face-to-face GP care include:

- Individual GPs provide in-reach face-to-face GP services. Acting essentially as Medicare-funded independent contractors, they will personally carry all of the consequent risks, including loss of usual income, illness, death and the transmission of COVID-19 to family members; and additionally be providing many hours of services for which there is no MBS funding (e.g. contacting families and other GPs, writing prescriptions, charting medications, recording clinical notes, educating staff). Anecdotal evidence from Melbourne RACFs affected by COVID-19 is that individual GPs (or even practices) that provide clinical services in this way are very few and far between, and effectively "throwing themselves on the fire".
- GPs, as employees or contractors to a larger service, provide face-to-face services
    - Local public hospital service
        - GP are employed as GP VMOs to provide face-to-face RACF care
        - a Local Health District in NSW is reported to be taking this approach
    - Local private hospital services
        - In Melbourne, recruitment of GPs to provide care for RACF patients transferred to private hospitals has been occurring (e.g. Healthscope)
    - Regional GP service (e.g. Aged Care GP[46])
        - Under current conditions, they would still face the same resource/funding challenges to providing face-to-face care as individual GPs
        - However, these services (or other existing GP services in a region, such as Federally-funded GP COVID-19 respiratory clinics, or not-for-profit GP collaboratives) could be leveraged to establish GP RACF face-to-face services – but would require significant support/funding support to do so
    - Locum agencies – such as Health Care Australia
    - Federally contracted services – such as Aspen Medical
- With appropriate funding, GPs providing services as employees or contractors could be supported with access to formal clinical governance structures, training, peer support, PPE and remuneration that is not dependent on access to or the presence of appropriate MBS items numbers.

4.4 Changing the status quo – expanding GP roles in RACF COVID Management

If the status quo is accepted, and no additional support is provided, then the involvement of GPs will most likely remain limited to providing non-COVID telehealth care in mild severity outbreaks, with State health systems bearing the brunt of meeting both the COVID and non-COVID medical needs of RACF residents in clusters of moderate and high severity.

[45] https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-caseconf-factsheet.htm
[46] http://www.agedcaregp.com/

This would be suboptimal. WHO recognises that, "*People with long-term care needs often require continuous, complex and personalised support structures [and] benefit enormously from continuity of care*", and one key action drawn from this is to "*Ensure that all long-term care facilities are supported by a primary care service*".[47] At Newmarch, despite a Hospital in The Home service, a Virtual Aged Care Service, and a 24/7 GP (presumably) telehealth roster, there was *"…a lack of adequate provision of medical care of the majority of residents who remained COVID-19 free, noting that this was not the responsibility of the HITH program*."[48]

If there is the will to expand the role of GPs in what is effectively a disaster response situation, however, it must be done in a deliberate, safe and sustainable manner.

The better utilisation of GPs in disasters is not a novel concept. Following Australia's Black Summer of 2020, the Medical Journal of Australia noted:[49]

"Disasters in Australia in recent years have all, inevitably, involved responses from GPs. They live and work in the communities that are struck and manage 95% of the community's health care, but little of their response is reported or documented… This is where the experiences of our community health providers are critical. GPs living and working in the community are a keystone of that community's wellbeing…In examining the literature one could be forgiven for concluding that GPs were not involved. However, they are intimately involved as trusted local community health professionals often stepping up to a self-defined role to aid their community during its worst adversity.

[There] is an urgency in integrating GPs into disaster systems. ***This requires embedding them in local, state and federal disaster plans and policies, including GPs or representatives in planning meetings and exercises through the PHNs, and in clearly defining their roles in all phases of disaster management. This also requires funding for establishment and sustainment of the GP capability****."*

4.4.1 Defining GP roles in RACF COVID-19 Outbreaks

There are a number of levels of GP involvement that could be considered, some of which have already been touched on:

- Care provision – RACF-specific
    - Direct face-to-face resident care
        - COVID-positive residents
            - Specific residents of a GP
            - All residents in the RACF
        - COVID-negative resident
            - Specific residents of a GP
            - All residents in the RACF
    - Telehealth resident care
        - COVID-positive residents
            - Specific residents of a GP
            - All residents in the RACF
        - COVID-negative resident
            - Specific residents of a GP

[47] https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1
[48] Newmarch House COVID-19 Outbreak Independent Review
[49] https://insightplus.mja.com.au/2020/3/building-gp-capacity-in-times-of-disaster/

            - All residents in the RACF
        - Teleconferencing/case-conferencing
            - provision of clinical/social information to and consultation with a clinician/proxy providing face-to-face care (e.g in-reach medical team, HITH medical staff, locum medical staff, on-site GP)
- Care provision – regional/surge workforce
    - Direct face-to-face resident care
    - Telehealth resident care
- Coordination
    - RACF-specific GP communications lead
        - Connect RACF GPs on a common communications platform
        - Act as a conduit for information from RACF to other RACF GPs
        - Potential to:
            - Lead planning and preparation discussions with their RACF
            - Lead medical communications to RACF families, pre- and post-outbreak
            - Participate in RACF Outbreak Management Team
            - Coordinate rostering for GP-services to their RACF
    - RACF regional GP coordinator
        - Coordinate, support and, where necessary augment, the RACF-specific GPs communication leads
        - Coordinate regional GP surge workforce
        - Liaise with regional Public Health Emergency Operations Centre (or equivalent)

For all of these roles, particularly in the event of a moderate to severe outbreak, in any one RACF (or region) there may need to be a separate GP in each role – and perhaps even multiple GPs in some roles (e.g. on a rotating roster)[50]. Conversely, for an outbreak of mild severity, one GP may be able to fulfil multiple roles.

In any one RACF, there cannot be an assumption that there will be GP(s) able to or willing to undertake or indefinitely continue any of these roles, especially under current (largely unfunded) conditions, as severity of an outbreak varies, and as personal circumstances change (e.g. other responsibilities, exhaustion, illness, death). There must therefore be a recognised sequence that can be followed when a role is remains vacant or is vacated, for example:

A. RACF GP cannot/can no longer provide face-to-face care for his/her COVID-negative residents

1. Can other RACF GPs provide face-to-face care?
2. Can regional surge GP workforce provide face-to-face care?
3. Can locum medical service provide face-to-face care?
4. If no to all of the above, face-to-face care for resident falls to in-reach hospital team/HiTH
5. Can usual RACF GP support face-to-face clinician via teleconferencing?

B. RACF GP cannot/can no longer function as the RACF GP communications lead

1. Can another RACF GP be the RACF GP Communications lead?
2. Can regional surge GP workforce provide an acting RACF GP Communications lead?
3. Can the RACF regional GP coordinator act as RACF GP Communications lead for the facility?
4. If no to all of the above, responsibility for GP coordination falls to the RACF Outbreak Management Team

[50] To mitigate exhaustion, particularly for face-to-face care, a rotating roster should be considered whenever possible

Once again, the probability of GPs filling any of these roles, even temporarily, would be substantially increased if there was adequate support and funding for them. Re: funding, there are two main avenues through which additional resources can be channelled to assist GPs in their participation in these roles – RACF COVID-19-specific block-funding to PHNs; and the MBS.

4.4.2 Funding PHNs to support RACF GPs

The formation of RACF communities of practice could facilitate communication and mutual support between GPs at both individual RACF and regional levels. Furthermore, although the difficulty of doing so should not be underestimated, RACF communities of practice could be leveraged to establish GP "surge" workforce, via clinical-care collaboratives.

To enable the above, **PHNs could be allocated specific block-funding by the Department of Health to help establish, support and develop RACF GP communities of practice.** For example, a regional RACF GP coordinator and a regional RACF Project Manager could be appointed out of these funds to lead this in each PHN, with additional resources reallocated as needed from within the PHN (e.g. practice support officers). Responsibilities could include:

- Surveying the RACFs in their region, including collating which GPs attend each RACF;
- Connecting GPs attending RACFs into RACF-specific and regional RACF communities of practice (e.g. via Basecamp, Teams, Slack, Telegram, or Whatsapp);
- Determining if there is/are GP(s) at each RACF that would consider being the lead communications GP at each RACF (RACF/OMT to GP, GP to GP), and what supports would be needed for the role; such as administrative support, resources to support planning and preparation discussions with RACF, resources to support family video-conference discussions pre-outbreak, support from the PHN regional RACF GP coordinator to deliver or facilitate family video-conference discussions, remuneration at a PHN-provided hourly rate[51]
    - This role should not, by default, be conflated with the role of a GP providing face-to-face care in a RACF
    - Where there were no GPs at a facility willing to take on that role, this could fall back to the PHN regional RACF GP coordinator, where they still had capacity.
- Determining what services each GP would consider continuing in the event of a COVID-19 outbreak, and what supports they would need to delivery these services, such as:
    - Telehealth – devices/tablets, internet access, agreed video conferencing platform (ideally uniform across the region), RACF staff training
    - Face-to-face care – RACF GP roster development, PPE, PPE training/drills with a IPC specialist; GPs employed by the local public health service, an alternative local healthcare organisation (e.g. federally-funded GP respiratory clinics, regional GP after hours cooperative), or local workforce agencies (e.g. HCA) or that can be specifically funded by the PHN to provide clinical governance oversight and an hourly rate.
        - The pre-emptive employment by local healthcare organisations of local RACF GPs as GP VMOs (e.g. on zero-hour short-term contracts) to provide face-to-face RACF care would provide medical cover that was better informed by local knowledge of the residents, families and the facility than could be provided by out-of-area locum medical staff, as well as being more economical.

[51] Or potentially access to new MBS item numbers for RACF GP planning/preparation/management. This would be very complex, however, as the scope of duties is very broad and difficult to delineate.

        - It is noted that public hospitals are ubiquitous, and have well established human resource, clinical governance and IPC procedures in place.
- Determining if there was interest in the regional RACF GP community of practice to create a regional surge GP workforce, which could provide telehealth-based and/or face-to-face surge medical services
- In discussion with funders (Department of Health, State Health, private hospitals, locum medical agencies), facilitate and/or provide the support their regional RACF GPs require to deliver RACF GP services that are evaluated as being beneficial, viable, sustainable and safe

4.4.3 Changes to the MBS to support RACF GPs

- There is confusion about whether COVID-positive residents who being treated by "Hospital In The Home"-type services are "inpatients", and whether the MBS can be billed for GP services related to those patients. This uncertainty is a barrier to the provision of GP care to COVID-affected RACFs that should be resolved expediently.[52] If this issue can be resolved, the following MBS changes, specifically applicable to RACFs affected by COVID-19, should be considered:
    - Case Conference MBS items 735 – 758[53]
        - Case conference MBS items could be used not only by an off-site GP to provide information to on-site public hospital/locum doctors about their residents, for also by an on-site GP to contact an off-site GPs about one of their residents.
        - RACFs GPs (whether on-site or off-site) could also use the item numbers to contact family members.
        - To allow for the above, however, the descriptors would need to be modified. Specifically for residents in COVID-affected RACFs, remove:
            - the need for formal discussion/consent
            - the minimum 15 minute requirement (add an additional "level A"/MBS item 3-equivalent item number if necessary)
            - the requirement for a minimum of three participants
    - Telehealth MBS items (91790 – 91802, 91795 – 91811)[54]
        - Telehealth, where it remains a viable means of delivering medical services, can facilitate the ability to surge regional telehealth RACF GP services (e.g. as arranged via a regional RACF GP community of practice) to an affected residential facility (e.g. aged care, disability care)
        - This would require an additional exemption to the "existing relationship" requirements (e.g. "*The existing relationship requirement does not apply to…residents living in a COVID-19 affected residential facility*"), as an affected RACF may not necessarily be in an area that is defined as "COVID-19 impacted".

The issue of providing primary medical workforce to RACFs with COVID is complex. The variables to consider are many. In the words of a Victorian in-reach geriatrician, "*…we've had to be appreciative of that, and flexible in our response depending on what the situation on the ground would be. Which is sometimes a bit of a difficult and less appreciated nuance to this. When we are working alongside GPs, we want to identify*

[52] One suggestion put forward is to make a COVID-19 RACF exception similar to the COAG s19(2) Exemptions Initiative https://www1.health.gov.au/internet/main/publishing.nsf/Content/COAG%20s19(2)%20Exemptions%20Initiative
[53] https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-caseconf-factsheet.htm
[54] http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-TempBB

what they are willing, what they are able to do, and make sure we try to harmonise as best as possible and play to our strengths, rather than duplicating and getting in each other's way."

The more primary care co-ordination and supporting infrastructure is in place before a COVID outbreak, the better the chance of a better coordinated and more efficacious GP response. However, it is clear that there will not be a single primary care solution that will work universally across all RACFs in all regions. The key will be planning, preparation, fluid inter-agency communication, and flexibility.

4.5 Other Issues of Concern

4.5.1 Residential disability care providers

Many of the issues confronting RACFs re: COVID-19 are mirrored in residential disability care services. In Victoria COVID-19 has affected more than 30 residential disability services and over 40 residents and staff.[55]

If PHN-supported regional RACF GP communities of practice can be successfully established, consideration should also be given to expanding similar supports to:

- Residential disability care providers
- At-home aged care providers

4.5.2 "Decanting"

There is active debate about whether RACF residents with COVID-19 should, in all cases, be "decanted" from the RACF into a different facility. This is a decision that primarily lies with state health authorities rather than GPs. Should this happen it would formally shift medical care from GPs to state health. In itself, it is debatable whether this universally leads to a better outcome.

The primary argument put forward to support "decanting" is that it is a public health measure that will substantially decrease the risk of disease transmission to other residents and members of staff.

From the Royal Commission into Aged Care, 10th August 2020:[56]

- *"…the federal Aged Care Safety and Quality commissioner Janet Anderson described NSW's initial reluctance to move aged care residents who tested positive for COVID-19 into hospital - a process known as transferring - as " intolerable and unsupportable"."*
- *"Mr Rozen [QC assisting the Royal Commission] cited a series of emails showing NSW's policy of caring for aged care residents who were sick with COVID-19 in the nursing home - known as 'Hospital in the Home' - was ageist."*
- *"Of the 37 residents who tested positive to COVID-19 at Newmarch House in Sydney, only two were transferred to hospital. One of those died. The other 16 residents who died of COVID-19 were all treated at Newmarch House, Mr Rozen said. In contrast, six residents died at Dorothy Henderson Lodge, where 13 of the 16 positive cases were sent to hospital. The commission heard that Dorothy Henderson Lodge had appointed two specialists in infection control within 24 hours of an outbreak, and the initial response was to move even those residents with mild symptoms to hospital. In contrast, there was a delay of nearly two weeks at Newmarch in getting infection control experts."*
- *[Janet Anderson said,] "To be clearer – if there is a view sitting behind the NSW Health position that aged care residents with COVID-19 should always be cared for in situ and should not be transferred to a hospital in any circumstances, then WE MUST CALL THIS OUT as an intolerable and unsupportable assumption."*
- *Professor McLaws, a WHO advisor on the pandemic, said the evidence from overseas showed "the attack rate", once a resident had tested positive, made it very difficult to keep the rest safe. "And the attack rate can go from anywhere between very negligible up to 100 per cent. So it's very difficult."*

[55] https://www.theguardian.com/australia-news/2020/aug/07/more-than-30-residential-disability-services-linked-to-covid-19-outbreaks-in-victoria, https://www.dhhs.vic.gov.au/coronavirus-update-victoria-29-august-2020

[56] https://www.smh.com.au/national/covid-19-has-exposed-australia-s-aged-care-sector-s-flaws-royal-commission-hears-20200810-p55k7p.html

On the other hand, the reported experience in Melbourne is that in the vast majority of cases, by the time the first diagnosis has been made several other residents have been infected, and so removing the one case that the RACF is aware of is not clearly or universally beneficial. In the case of Hong Kong, which had no RACF deaths in their first two waves, and is frequently lauded for their policy of transferring all COVID-positive residents to public hospitals, there are now multiple residential facilities with significant COVID-19 outbreaks despite their transferring policy (e.g. *Kong Tai Care for the Aged Centre*, with 46 COVID-19 positive residents and 9 fatalities[57]) and Hong Kong has additionally been reported as being close to exhausting their allocated public hospital COVID-19 hospital bed capacity.

One of the principles of emergency management is that "*Responsibility for preparation and risk management rests at the local level in the first instance. Emergency response and recovery are conducted at the lowest level of effective coordination. Resources and support are augmented by Region and State level coordination as required.*" [58] Concern has been expressed that having a formal policy of transferring COVID-positive patients from RACFs would led to some RACFs effectively absolving themselves of their responsibility to contribute to increasing the disaster resilience of the whole system, and thus not rigorously preparing for the possibility of having to deal with COVID-19 that has already spread asymptomatically to other residents. In a pandemic situation, especially as the severity increases, all parts of systems will be stretched, and for the benefit of the whole, every part must maximise the role it can play. And, in fact, the "lived experience" in Melbourne has been that in some (or even most) facilities, COVID-19 has been contained successfully – in other words, "wildfire" spread of COVID-19 in RACFs is not inevitable.[59]

Ultimately, however, the unclear public health benefit does not obviate transferring a COVID-positive resident to another facility where there is capacity to do so, and/or where are other reasons for transferring the resident(s). In particular, where an emergency response is *not effective* at "the lowest level", there must be a trigger for escalation. In Melbourne RACFs, the most common trigger for escalation/transfer has been when the poverty of staffing compromises the provision of basic care. The Newmarch independent review[60] also indicates that utilising Hospital in the Home Services for COVID-19 positive patients is only likely to be safe "*…if the outbreak is limited to a small number of cases in residents and staff.*"

There are other tensions at play, underpinned by public-private and federal-state divisions. For private RACF operators, who are federally funded, managing COVID19-positive residents in their facilities comes at a tremendous cost to both their human and financial resources[61,62], as well as carrying a large reputational

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[57] https://ph.news.yahoo.com/amphtml/hong-kong-third-wave-death-052005183.html

[58] *"Responsibility for preparation and risk management rests at the local level in the first instance."* https://www.emergency.nsw.gov.au/Documents/publications/20181207-NSW-state-emergency-management-plan.pdf

[59] This particularly appears to be the case in newer facilities where physical cohorting (e.g. in different wings) is possible.

[60] Newmarch House COVID-19 Outbreak Independent Review

[61] "*The sudden departure of almost all regular carers and RNs was a major blow to both residents and management. The facility was staffed for several days, by managers and volunteers for other areas of the BaptistCare business…Agency nurses were provided by Health Care Australia (HCA). More than the usual staff complement was needed, because of the additional workload…and it was often difficult to secure adequate numbers, as many worked part-time and/or at other facilities…Some staff had to be flown in from interstate or elsewhere in NSW, adding transport accommodation costs. The total staff costs have been enormous and presumably could not be sustained by a smaller, less well-resourced organisation*." Review of Dorothy Henderson Lodge (DHL) COVID-19 Outbreak

[62] "*We incurred additional costs of approximately $2.4 million in managing the outbreak at DHL, with approximately $1.7 million relating to additional workforce costs…This was exacerbated by a decrease in income during the outbreak as we could not admit new residents. This placed further financial pressure on the home…The Australian Government has provided the COVID-19 Aged Care Support Program, a grant scheme to recompense providers for abnormal costs associated with a COVID-19 outbreak and we are in the process of applying for funding to offset some or all of these*

risk. For state health services, every resident moved out of a private RACF facility into a public facility also transfers these costs and risks to the state. In Melbourne, an additional issue that has arisen is that RACFs may be reluctant or unable to repatriate residents once admitted, resulting in additional pressures on public hospital resources.

The Newmarch independent review notes the complexity of the decision-making involved, as well as suggesting residents should be transferred to hospital until the RACF is deemed safe.[63] On this issue, Paul Rozen QC (Counsel Assisting the Aged Care Royal Commission) has written, "*We readily acknowledge that the issue is complex and cannot be approached on a 'one size fits all' basis.*"[64]

In practice, the hope is that whether or COVID residents in any one RACF will be transferred to another facility should be dependent primarily on patient and broad health-system orientated factors, including:

- What is the preference of the resident and their family?
- With consideration to remaining staff, what is the true capacity of the RACF to continue to co-ordinate and deliver basic patient services?
- With consideration to remaining staff, RACF infrastructure, efficacy of prior planning & preparation, and the resident case-mix, what is the capacity of the RACF to minimise transmission risk within the facility – to both other residents *and* staff?
- What is the remaining capacity of external agencies to assist the RACF as necessary? (e.g. local state health services, locum nursing agencies, locum medical agencies, local GPs).
- What is the remaining capacity of external agencies to accept the transfer of residents from the RACF? (e.g. public hospitals, other public facilities designated as COVID-isolation units, private hospitals.)[65]

5 Recommendations

5.1 General RACF planning/preparation

Attending GPs are encouraged to

- engage with RACF management

costs. At the time of writing we do not know what amount the Government will cover." Royal Commission Submission by BaptistCare NSW&ACT (Dorothy Henderson Lodge)

[63] "*Decisions about the management of COVID-19 cases should be made by an expert panel. The panel should at minimum include membership from experts in infectious diseases, infection control, geriatric medicine, clinical leadership from the approved provider and a local general practitioner. This panel should consult with the relevant Commonwealth and jurisdictional health agencies, the Aged Care Quality and Safety Commission and the designated representative of the Approved Provider. As the soon as an outbreak is declared: (i) the expert panel should be convened and (ii) residents should be transferred to hospital until the residential aged care facility is deemed safe and appropriate for residents to return.* ***NB:*** *Implications of such decisions will need to be considered in light of individual resident's personal preferences*." Newmarch House COVID-19 Outbreak Independent Review

[64] https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/Sydney%20Hearing%202%20-%20Counsel%20Assisting%20written%20submissions%20-%2014%20August%202020_0.pdf

[65] Particular challenges are likely in regional/remote locations re: both assistance from external agencies/replacement workforce, and access to health facilities to transfer RACF patients to

- be familiar with the planned sequence of actions when a RACF outbreak occurs, including the roles and responsibilities of the many stakeholders[66]
- participate in facility COVID-19 planning
    - Recommend the use of "*COVID-19 Lessons Learned for Aged Service Providers*"[67] as a practical guide to supplement existing plans, noting recommendations such as "*Staff training on infection control undertaken and refreshed continuously and documented, including physical training in the donning and doffing of PPE and the establishment of super users and spotters*"[68], *"The plan needs to be stress tested to deal with initial infection and widespread outbreak scenarios."*[69]
    - Encourage "zoning" of the facility prior to a known outbreak (e.g. Zones A, B and C). Zones should be clearly marked. If residents and staff are split between these zones with no cross-over, this limits the number of staff that need to be furloughed in the event of an outbreak
    - Encourage the recording of baseline oxygen saturations and the daily use of the "*COVID-19 screening tool for residential aged care services"*[70] as a mechanism to facilitate the early detection and isolation of COVID-19 in the RACF.[71]
    - Acknowledge the combination of community transmission plus entry into the RACF by care staff (including visiting GPs) as the main risk factor re: COVID-19 ingress into a facility
        - Encourage the restriction of movement of care staff between different RACFs
        - In consultation with your local public health unit, consider implementing a facility and regional zoning system. For example:
            - RACF with known COVID-19 is designated RED – staff from this facility must not be shared with another RACF
            - Known hotspots for community transmission designed AMBER – staff residing or working in these areas must wear (at a minimum) surgical masks and face-shields when in the RACF
    - Put in place (documented and easily retrieved) procedures that will allow the entire RACF to safely operated by completely new staff unfamiliar with either the facility or the residents
    - Gain access to RACF IT systems

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[66] See Appendices 1, 2, 3 & 4 for a summary of some relevant official COVID-19 planning documents (some are NSW based)

[67] https://lasa.asn.au/wp-content/uploads/2020/08/LASA0759_COVID-19-Lessons-Learned-v4-1.pdf

[68] "*Whilst Newmarch House had previously managed infectious disease outbreaks such as influenza and gastroenteritis, the standard of infection prevention and control (IPAC) practice required to manage a COVID-19 outbreak is now known to require a higher-level focus and skillset. This involved extended use of personal protective equipment (PPE) and the stringent application of IPAC principles not generally seen in residential aged care. Many staff were ill prepared, despite additional training and the existence of current infection control policies, which had been regularly reviewed as part of Newmarch House's previously successful accreditation record.*" Newmarch House COVID-19 Outbreak Independent Review

[69] *"Whilst Anglicare had developed and already commenced implementation of a COVID-19 action plan, the plan could not have anticipated the scale of the outbreak or the sudden and extensive depletion of its regular staff (including two on-site managers and its surge workforce) or the difficulty engaging agency staff. This led to the enormous challenge of subsequently delivering person-centred care, with few remaining staff who knew and understood the residents' individual needs and too few staff, overall, to manage the increased workload during the first weeks of the outbreak. Nor did the plan allow for rapidly increasing numbers of seriously ill and dying residents in the home and the ensuing crisis and tragedy which ultimately occurred."* Newmarch House COVID-19 Outbreak Independent Review

[70] https://www.bettersafercare.vic.gov.au/resources/tools/covid-19-screening-tool-for-residential-aged-care-services

[71] It is acknowledged that the sensitivity of the tool may present practical difficulties in its full implementation, especially re: recommended isolation triggers, and may need to be tempered against knowledge of local transmission rates. See Appendix 13.

- Clarify RACF and local health service (in-reach services, hospital in the home, palliative care, public health unit, COVID-19 inpatient unit) expectations of GPs in an outbreak, for example:
  - who will provide medical care for
    - COVID-19 positive patients
    - negative patients
  - what are the trigger points for transfer to other facilities for
    - COVID-19 positive patients
    - COVID-19 negative patients

5.2 GP specific preparation

5.2.1 Documentation

- Prepare documentation for each resident, to be used in the event of the patient being transferred to another facility, and/or the medical care for the patient being transferred to another agency (e.g. hospital in-reach, locum medical agency), and/or the staff at the RACF no longer being able to access the electronic medical record (e.g. due to all regular staff with IT access being replaced). Where feasible, these documents should also be uploaded to MyHealthRecord. Documentation should be reviewed/up-to-date, and include:
  - GP sourced:
    - Medical summary
    - Medications
      - Current medical list – consolidate where possible, replace nebulised medication with spacers
      - Chronic disease anticipatory medications (e.g. cardiac failure) – charted pre-emptively
      - Palliative care medications - charted pre-emptively
      - A set of current PBS prescriptions (to be utilised if patient is transferred to a private hospital[72]
    - COVID-19 specific Goals of care documentation[73]/Advanced care plan[74]/up-to-date escalation plan
      - Updated in the context of COVID-19
      - CPR should not be offered for residents known to have COVID-19
      - Ensure family is aware of the plan – consider holding group video conferences with RACF families (*see 5.2.3*)
    - GP contact details
  - RACF sourced:
    - One-page/brief nursing care plan
      - Review use of/need for CPAP and BiPAP
    - Identification bracelet for the patient
    - Recent picture of the resident

[72] will have to be prominently dated and redone if patient medications are changed
[73] See Appendix 11 and 12 for sample "Goals of Care" documents
[74] https://www.advancecareplanning.org.au/for-health-and-care-workers/covid-19-web

        - Family/person responsible contact details – minimum of three recommended[75]

5.2.2 Provision of GP services

- Minimise infection risk from GP visits
    - Schedule RACF visits prior to GP sessions, or on separate days
    - Co-ordinate/consolidate visits with other GPs visiting RACF
    - Visit COVID-19 negative patients first
- PPE
    - Discuss expectations re: PPE protocols and supply with RACF
    - Wear full PPE when visiting RACFs, particularly if there is known local community transmission
    - Practice donning and doffing PPE with a spotter
    - When doffing PPE, do it with a spotter, and do it *slowly* – this is the highest risk event for self-contamination
    - When moving from a COVID-positive patient to another COVID-positive patient, keep eyewear/mask on but change gown and gloves
    - Even with PPE, minimise contact with COVID-positive residents – only do a physical examination if absolutely necessary
    - Have processes in place for protecting your family (e.g. laundry management, self-isolation where possible)
- Environmental scan
    - Clarify with your local public health services what roles they will play in RACF outbreak(s), and what roles they expect GPs to play
    - Clarify with your local PHN what assistance they have and will provide to GPs, from planning and preparation through to response – see below for *Establish RACF GP communities of practice*
    - Clarify with any regional after hours services what role they will play
    - Be familiar with your RACF outbreak management plan and the document "*First 24 hours – Managing COVID-19 in a Residential Aged Care Facility*"[76]
- Establish RACF GP communities of practice
    - For mutual support, including the dissemination of important information, and to facilitate the communication with resident families, form communities of practice with:
        - GPs attending individual RACF(s)
        - GPs attending RACFs in GP region
    - Multiple platforms could be utilised to do the above, including:
        - Instant messaging platforms (e.g. Skype, Telegram, Whatsapp)
        - Online collaboration platforms (e.g. Basecamp, Microsoft Teams, Slack)
    - Within your RACF GP Community of Practice, establish:
        - If anybody would be willing to be a "GP communications lead", to primarily function as a contact point for the RACF to disseminate information to other GPs attending the RACF? Any further roles beyond this (e.g. participation in a RACF Outbreak Management Team) would have to be defined and agreed upon.
        - Would anybody be willing to be back up the "GP communications lead" in the event that the "lead GP" was unavailable?

[75] Newmarch House COVID-19 Outbreak Independent Review

[76] https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility; summary in Appendix 1

- Establish what services individual GPs would be willing to consider in the event of an outbreak? For example:
    - Withdrawal of RACF services (e.g. from one RACF where a GP has 2 residents, to focus on another two RACFs where the same GP has 60 residents)
    - Telehealth (where the RACF has and retains that capability)
        - Provision of telehealth services only, for COVID positive and/or negative residents of that GP only
        - Provision of telehealth services only, for all COVID positive and/or negative residents of a RACF
        - Provision of telehealth services to residents in other RACFs, where the need arises
    - Face-to-face services
        - Provision of face-to-face services for COVID positive and/or negative residents of that GP only
        - Provision of face-to-face services for all COVID positive and/or negative residents of a RACF
        - Provision of face-to-face services for residents in other RACFs, where the need arises
    - Teleconferencing/case-conferencing
        - Provision of information and/or clinical advice to a medical officer (e.g. hospital in-reach, HiTH, medical locum, on-site GP) providing face-to-face services for one of their residents
    - Participation in a roster for any of the above
- If able to establish a regional RACF Community of Practice, approach the regional Public Health Unit/Regional Emergency Operations Centre and ask if a representative could join the CoP; alternatively, could a GP representative be included in the regional public health Emergency Operations Centre (or equivalent)?
- Seek the assistance of the local PHN to help coordinate and facilitate the:
    - Regional coordination of the RACF GP COVID-19 response
    - The establishment of RACF GP communities of practice
    - The co-ordination of communication to RACF resident family groups, particularly pre-outbreak (alignment of expectations and advanced care planning)
    - The co-ordination of telehealth-based surge RACF GP capacity, leveraging off the RACF GP communities of practice
        - It would be ideal if a single telehealth platform could be agreed upon across the PHN footprint
    - Consideration of the establishment of face-to-face surge RACF GP capacity via:
        - Local public hospital services
        - Local private hospital services
        - Locum medical services
        - advocacy/submissions to the Department of Health to establish face-to-face surge RACF GP capacity (e.g. leveraging off existing GP services such as federally funded GP respiratory clinic)
        - advocacy/submissions to the Department of Health to increase MBS access to GPs involved in RACF COVID-19 responses, and/or for PHN block funding to support GP involvement

- Triggers for withdrawal of service
    - Consideration should be given to when provided GP services must be withdrawn, such as the failure of supports leading to unacceptable risks to the physical and/or mental health of the clinician(s)
- Start planning for re-establishment/repatriation of residents

5.2.3 Establish communication channels

- GP to Resident - Telehealth
    - Ensure the RACF has the ability to conduct telehealth consultations
        - RACF administered
            - Provision of internet access, devices, platform
            - Designated staff to assist residents with device use (note this will degrade as staffing levels deteriorate)
            - If not already operational, practice telehealth consultations pre-outbreak
        - Patient administered
            - Where patients have their own mobile phones/devices and the ability to use them independently, collate their contact details so their GP can continue to contact them even when RACF capacity to assist deteriorates
            - Where patients are capable but do not have their own telephone, encourage families to provide one pre-outbreak
- GP to GP (+/- GP to regional public health services)
    - Utilise communication platforms developed for RACF GP communities of practice
    - Consider working with the Incident Management Controller / PHU so that once the first positive case of COVID is identified in a RACF, there is early communication to the clinical lead GP who then can co-ordinate communication to all other GPs associated with that facility
- Facility to GP & GP to Facility
    - In the context of phone lines to the RACF likely being constantly engaged, clarify how the RACF will contact GPs in the event of an outbreak/with a request for medical review/for notification of a change in patient status (e.g. transfer, death)
        - Consider a single communications channel (e.g. email or Whatsapp)
        - use the ISBAR format
        - accompany requests for clinical review with a copy of the medication chart
    - In the context of phone and fax lines to the RACF likely being constantly engaged and/or not regularly monitored, clarify how GPs will contact the RACF (e.g. dedicated mobile phone number, email/instant messaging platform as above), including for the notification of COVID-19 testing.
    - Arrange for remote access into RACF nursing and medical record software, if this has not already been done
- GP to family
    - This is a key element to reducing experienced distress in the event of a RACF outbreak
    - Even if an ACP already exists, hold advanced care planning and frank discussion with families to align expectation and possible outcome. This could be done pre-emptively in group video conferences.
    - Ensure that the family know that supportive care will continue and that all efforts will be made to address symptoms.

- Maintain regular family communication during a COVID outbreak, either in groups through regularly scheduled video conferencing, email or SMS, augmented where necessary with direct phone calls[77]
- Seek the assistance of the RACF[78] and the local PHN to help co-ordinate and facilitate the above

[77] The Newmarch experience highlights the importance of effective two-way communication: "*During the course of the outbreak, information sessions and meetings were conducted via Zoom for family members and actively promoted by the Older Persons Action Network (OPAN) via Facebook. OPAN reported some difficulty accessing contact details for the residents' nominated contacts. Family members complained that whilst the Zoom Webinars were informative, the lack of capacity for effective two-way communication meant that their concerns were often not addressed in a timely manner, if at all.*" Newmarch House COVID-19 Outbreak Independent Review

[78] "*…providers should develop and be ready deploy a dedicated team of staff to act in the capacity of a Family Support Program (however titled), providing person-centred, structured interactions with family members of residents affected during an outbreak. Protocols should be established to determine the frequency and type of contact with the nominated contact persons. Consideration should be given to the availability of furloughed staff to support this program to provide optimum levels of support to family members…[At Newmarch] The establishment of the Family Support Program (FSP) in early May was recognised as a turning point by many family members…The FSP team members were allocated to groups of residents in order to provide consistency and continuity with both staff and family members.*" Newmarch House COVID-19 Outbreak Independent Review

6 Summary of Risks & Suggested Risk Treatments

Situation	Risk	Outcome	Ability of GP(s) to influence	Suggested Risk Treatments
High proportion of RACF staff are casual and poorly paid	1. RACF staff working across multiple facilities 2. RACF staff more likely to work when symptomatic/unwell 3. RACF staff are less likely to have established relationships with visiting GPs	1. Increased COVID-19 ingress and transmission 2. Reduced engagement with visiting GP 3. Reduced involvement of GPs in outbreak planning/preparation	Low	1. Lobbying at State and Federal levels for appropriate support for staff to work at only one location in the event of elevated community transmission. 2. GPs/PHN discuss RACFs shared staff policy with RACF management 3. Discuss zoning within and between facilities pre-outbreak. *(see 5.1, 3.1.2)*
Loss of RACF staff	1. Reduced number of care staff in RACF 2. Reduced proportion of "regular" staff in RACF	1. Loss of leadership 2. Loss of corporate knowledge – about residents (identification, care needs, baseline medical status) and about facility (e.g. access to PPE storage, access to telehealth devices) 3. Inability to answer telephone or monitor faxes/emails 4. Inability to support telehealth consultations 5. Inability to provide basic care to residents -> need to transfer patients to another facility (state health or private)	Low	Encourage RACF to: 1. Review RACF plans for surge staffing (internal, external e.g. Mabel) 2. Review local state health plans for surge staffing, including triggers and escalation process 3. Review Federal plans for the establishment and role of an *Aged Care Health Emergency Operations Centre*[79], including triggers and escalation process 4. Provide identification bracelets for all residents 5. Include identification board in RACF with current photos and names of all residents

[79] https://www.health.gov.au/sites/default/files/documents/2020/08/guide-to-the-establishment-of-an-aged-care-health-emergency-response-operations-centre-guide-to-the-establishment-of-an-aged-care-health-emergency-response-operations-centre.pdf

				6. Provide and have easily accessible summary of current patient information (e.g. medical summary, medications, one-page resident care plans, advanced care planning, relative contact details, GP contact details) 7. Have a concise procedural manual in a central file to allow completely new staff to run the RACF independent of any of the current staff, including access to computer systems and telehealth devices *(see 5.2.1, 3.1.2)*
Correct infection control/PPE donning & doffing procedures are not rehearsed adequately pre-outbreak	1. Failure (a) to follow correct PPE procedures, (b) infection control procedures	1. Increased COVID-19 transmission 2. Increased resident morbidity and mortality 3. Loss of RACF staff confidence 4. Loss of RACF staff (furlough, morbidity, refusal to work)	Possible	1. Advocate for appropriately set-up donning & doffing stations; wall charts; repeated PPE drills; use of a spotter; dedicated RACF "PPE days" 2. Arrange to: a. Schedule RACF visits prior to GP sessions, or on separate days b. Coordinate/consolidate visits with other RACF GPs c. Visit COVID-19 negative patients first *(see 5.2.2, 3.1.3)*
RACF resident with early symptoms of COVID-19 is not recognised	1. RACF resident with COVID-19 is not diagnosed early	1. RACF resident with COVID-19 is not isolated early 2. Increased COVID-19 transmission 3. Increased resident morbidity and mortality	Likely	1. Advocate for daily use of the "COVID-19 screening tool for residential aged care services"[80] 2. Reinforce need to test for COVID-19 for any new symptoms *(see 5.1)*

[80] https://www.bettersafercare.vic.gov.au/resources/tools/covid-19-screening-tool-for-residential-aged-care-services

		4. Loss of RACF staff confidence 5. Loss of RACF staff (furlough, morbidity, refusal to work)		
Inadequate or absent MBS funding for non-COVID related GP services being provided to RACFs (e.g. prescriptions)	1. Pre-COVID, low GP participation rate re: provision of care to RACF residents	1. Burden of non-COVID related medical care provision falls to state health and federally contracted agencies (e.g. HCA, Aspen Medical), who may or may not be able to meet needs of RACF residents 2. If needs are not met, there will be poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs); and the need to transfer patients to another facility (state health or private)	Low	1. Advocate for increased access to MBS items for RACF-related GP services *(see 4.1)*
Inadequate or absent MBS funding for COVID-related GP services being provided to RACFs (e.g. preparation, planning, management)	1. In the event of an outbreak, with increased risk and cost (e.g. PPE), reduced likelihood of ongoing GP-participation in RACF care provision 2. Absent remuneration for many aspects of COVID-related planning, preparation and management	1. Burden of COVID-related medical care provision falls to state health and federally contracted agencies (e.g. HCA, Aspen Medical), who may or may not be able to meet needs of RACF residents 2. If needs are not met, there will be poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs); and the need to transfer patients to	Possible	1. Advocate for increased funding (e.g. via PHNs) for RACF GPs to engage in these activities, +/- for increased access to MBS items for RACF-related GP services *(see 4.4.3)*

		another facility (state health or private)		
GP(s) independently/under existing funding arrangements and without additional supports provide ongoing RACF care in the event of an outbreak	1. Care provision is unsustainable	1. Harm to GP(s) involved 2. GP(s) involved may not be available to provide care to repatriated residents 3. Burden of medical care provision falls to state health and federally contracted agencies (e.g. HCA, Aspen Medical), who may or may not be able to meet needs of RACF residents 4. If needs are not met, there will be poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs); and the need to transfer patients to another facility (state health or private)	Possible	1. Increase resilience of facilities and GPs via improved planning and preparation 2. Advocate for funded supports (e.g. via PHN) for GPs providing aged care services, including connection to RACF-specific and region-wide communities of practice, on a common communications platform (e.g. Telegram, Whatsapp, Basecamp) 3. Advocate for funding for dedicated regional support personnel (e.g. a regional GP RACF coordinator and a Project Manager) *(see 4.4)*
Resilient communications channels not established between RACF/Outbreak Management Team (OMT) and GP(s)	1. GPs are not informed out RACF outbreak 2. GPs are unable to contact RACF to gain information or to provide care	1. GPs are not engaged in outbreak management. Burden of medical care provision falls to state health and federally contracted agencies (e.g. HCA, Aspen Medical) 2. GPs are unable to communicate with families in an informed way 3. GPs are unable to provide medical care by telehealth	Possible	1. Establish dedicated phone number for GPs and other essential services (e.g. mobile phone number held by the RN/RACF manager) 2. Consider a single communications channel (e.g. email or Whatsapp) for written requests a. use the ISBAR format b. accompany requests for clinical review with a copy of the medication chart

				3. Arrange for remote access to RACF software pre-outbreak 4. Obtain direct telephone numbers of residents where they exist; where residents are capable but do not have their own telephone, encourage families to provide one pre-outbreak 5. Advocate for additional funding as necessary (e.g. block funding of PHNs to dedicate staff to increase planning, support and co-ordination of the regional GP RACF response, including exploring the provision of face-to-face GP services) *(see 5.2.3, 3.1.5, 4.4,3.2.2)*
Communication channels not established between GPs providing services (a) to an individual RACF, (b) to RACFs in a region	1. GPs are unable to access RACF nursing and medical software 2. GPs are unable to share information 3. GPs are not connected to a supportive community of practice	1. GPs are unable to provide ongoing, well-informed care 2. Inefficient communication from RACF to GPs 3. GPs are dependent on RACF(s) to provide information, at a time when the RACF capacity to communicate is likely to be severely degraded 4. GPs are not supported by their colleagues (e.g. provision of information, advice, surge workforce)	Possible	1. Connect GPs to RACF-specific and region-wide communities of practice, on a common communications platform (e.g. Telegram, Whatsapp, Basecamp) *(see 5.2.3, 4.4.2)*
Communication channels not established between GPs providing services to RACF(s) and the families of RACF residents	1. GPs/RACFs are unable to efficiently engage RACF families in aligning expectations and advanced care planning	1. Poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs)	Possible	1. Connect GPs and families pre-outbreak to a common communications platform with group videoconferencing capability (e.g. Skype, Zoom), ensuring dial-in option

	discussion before an outbreak 2. GPs/RACFs are unable to efficiently communicate information to families in the event of any outbreak			2. Identify any families that need alternative communication mechanisms (e.g. translation services) 3. Discuss anticipated management of COVID-19 in the RACF 4. Discuss COVID-specific advanced care planning with families pre-outbreak 5. Ensure resilience of communication channels between GPs and RACF in the event of an outbreak, so GPs remain informed of the status of the RACF and RACF patients, and in turn can communicate accurate information to families *(See 5.2.3, 4.2.2, 4.5.2, 3.1.5, 3.1.6)*
GP role in RACF preparation and outbreak management is not clear	1. Confusion between agencies responding to an outbreak	1. poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs)	Likely	1. Develop relationships between GPs and other stakeholders (state health, primary health networks) 2. Seek the assistance of the local PHN to help co-ordinate and facilitate RACF GP services. 3. Define, establish and fund a "GP communications lead", "regional GP coordinator" etc. 4. Establish what services individual GPs would be willing to consider in the event of an outbreak 5. Approach the regional Public Health Unit/Regional Emergency Operations Centre to establish a connection 6. Communicate GP abilities to realistically respond to the

				pandemic within RACF, to these bodies, in the light of the experience of Victorian GPs *(See 5.2.2, 4.2, 4.3, 4.4)*
Mismatch of stakeholder expectations of GP role in outbreak preparation and management	1. Confusion between agencies responding to an outbreak	1. poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs)	Possible	1. discuss GP ability to respond to expectations in context of current and potential funding arrangements 2. advocate for additional funding as necessary (e.g. block funding of PHNs to dedicate staff to increase planning, support and co-ordination of the regional GP RACF response, including the appointment of a regional GP RACF coordinator and a Project Manager) *(See 5.2.2, 4.2, 4.3, 4.4)*
Triggers and processes for "decanting" not clear	1. Confusion and/or conflict between agencies and families involved in an outbreak	1. Poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs)	Possible	1. Clarify triggers and process for "decanting" with state health services 2. Communicate the above to stakeholders (GPs, RACFs, residents, families) *(See 4.5.2)*
Process for re-establishment/repatriation of residents not clear	1. Confusion and/or conflict between hospitals, RACFs and GPs	1. RACFs and/or GPs unprepared to receive discharged residents 2. RACFs refuse to accept discharged residents 3. Poorer resident outcomes, dissatisfaction of residents and families, reputational damage (RACF, State Government, Federal Government, GPs)	Possible	1. Ensure processes for RACF re-establishment/repatriation are clear, documented, and known to all stakeholders *(see 3.1.7)*

Many of the COVID-related challenges facing RACFs are mirrored in the residential disability sector	1. All of the risks as described for the RACF sector – in smaller facilities but with a less-trained workforce	1. All of the outcomes as described in the RACF sector	Possible	1. Lobby for regional support provided via PHNs to RACF GPs also be extended to GPs attending residential disability facilities *(see 4.5.1)*

7 Conclusion

Adequate staffing and effectively practiced infection control procedures are just some of the fundamentals that underpin the safe provision of care to RACF residents. These essentials have been severely tested by COVID-19. Whilst the ability of GPs to change many of these issues is limited, in less affected states and territories, we have the opportunity to build on the experience of our Victorian colleagues. This paper hopes to be a prompt for discussions and actions that will help define and broaden the role of GPs, both individually and collectively, in advocating for and participating in measures that:

- through improved planning and preparation, will reduce the number of affected RACF residents
- through the direct provision of care, will preserve medical care to residents and reduce pressure on the public hospital system
- through well-defined processes, will protect and preserve clinical staff, including RACF staff and GPs
- through better communication, will reduce the distress experienced by affected RACF residents and their families

The balance of evidence from the Victorian RACF experience of COVID-19 is that the greatest contribution GPs can make is to help prepare their patients, families and RACFs before an outbreak, and after an outbreak, to continue to communicate regularly with resident families.

GPs can also contribute to ongoing medical care needs, but to enable the safe and sustainable delivery of this will require specific funding to support planning and preparation.

8 Acknowledgements

- Dr Di Bridger, Aged Care Working Group, Hunter GP Association COVID-19 Response Unit
- Dr Jennifer Briggs, Aged Care Working Group, Hunter GP Association COVID-19 Response Unit
- Ms Akiko Fong, Clinical Trials Project Leader (Acting), Newcastle, NSW
- Dr David Fong, GP, cohealth, North Melbourne, Victoria
- Dr Bianca Forrester, GP and Project ECHO facilitator, West Vic PHN Hub
- Dr Carolyn Hullick, Emergency Physician, Newcastle, NSW
- Dr Gaveen Jayarajan, GP, Plexus Healthcare, Victoria
- Ass Prof Michael Murray, Geriatrician, Victoria
- Dr Sachin B Patel, Director, Aged Care GP, Victoria
- Dr Bernard Shiu, Managing Director, Banksia Medical Centre, Victoria
- Dr Jeff Urquhart, GP Liaison Unit, Barwon Health, Victoria
- Dr Joanne Wood, Aged Care Working Group, Hunter GP Association COVID-19 Response Unit
- Aged Care Emergency Service Interagency Group, Hunter New England Central Coast PHN
- Austin COVID Unit, Austin Hospital, Heidelberg, Victoria
- Doctors in Aged Care Facebook Group
- Hunter New England Central Coast HealthPathways, Hunter New England Central Coast PHN
- Project ECHO Western Vic PHN Hub: COVID 19 Pandemic Response ECHO
- All the medical and other healthcare workers involved in the Victorian RACF COVID-19 response

Appendix 1 - Australian Government Department of Health – First 24 hours – Managing COVID-19 in a Residential Aged Care Facility[81]

[Notes]

- Minutes 30-60
  - Isolate & inform the COVID-19 positive case(s)
  - Contact your PHU
  - Contact the Commonwealth Department of Health
  - Lockdown the residential aged care facility
  - Convene your outbreak management team.
    - The provider is responsible for managing the outbreak and taking a strong leadership role with support from the PHU.
    - The PHU will investigate cases and contacts and advise on infection control and isolation.
    - Bring together the outbreak management team to direct, monitor and oversee the outbreak. They will provide key decision making and crisis management during the outbreak. The team should include:
      - upper management
      - on-the-ground facility management, and
      - a person who can report on the current status and implement actions agreed by the outbreak management team.
    - Nominate an outbreak coordinator, and designate and agree key roles and responsibilities.
    - This team should comprise:
      - Chairperson (facility Director, Manager or nursing manager)
      - Secretary
      - Outbreak coordinator (nurse infection control practitioner or delegate)
      - Media spokesperson
      - Visiting GPs
      - Public health officers
    - A small number of staff may need to perform multiple roles in the team.
  - Activate your outbreak management plan
  - Establish screening protocols
  - Release an initial communication
    - Inform residents, staff, families and key stakeholders of a COVID-19 diagnosis within the residential aged care facility.
- Hours 2-3
  - Contact tracing
  - Identify key documents (floor plan, resident list, staff list – including people providing primary care) – like be collated on a line list (describes people infected in terms of time, place and person) with assistance from the PHU
  - PPE Stocktake
  - Communication – incoming calls in the first 24 hours alone could be 1000-2000

[81] https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility

- Hours 4-6
    - First meeting of the Outbreak management team – should continue to meet daily, will be supported by State Department of Health representative responsible for in-reach services, Commonwealth case manager to assist with PPE/supplementary pathology testing/surge workforce, Aged Care Quality & Safety Commission
    - Bolster your staff and plan your roster – up to 80-100% of workforce may need to isolate. More staff and a higher proportion of RN staff will be needed.
    - Conduct testing in conjunction with the PHU
    - Clinical management of COVID-positive cases
        - Clinically manage COVID-19 positive cases to address all their needs. Consider whether the resident's condition warrants a transfer to hospital. Do this in consultation with the resident.
        - Unwell residents must be reviewed by their GP regardless of whether an outbreak is present or not.
        - If a COVID-19 outbreak is present, all visiting GPs should be informed at the start of an outbreak. The facility should be engaging with the PHU and other relevant clinicians in these matters.
- Hours 6-12
    - Cohorting & relocation – older facilities where residents share rooms or bathrooms may require off site cohorting
    - Move to a command-based governance structure
    - Rapid PPE supply – the Commonwealth will facilitate this if required
    - Infection control – appointment infection control lead
- Hours 12-24
    - Clinical First Responder from Aspen to commence
        - The Commonwealth will arrange an Aspen Clinical First Responder on day 1 or 2 to assist:
            - reviewing preparedness for managing the outbreak,
            - analysing workforce capacity,
            - reviewing infection control processes,
            - assessing PPE stocks and competencies,
            - recommending enhanced cleaning protocols, and
            - assisting with any significant capability gaps.
    - Review advanced care directions
    - Establish strong induction and control processes
    - Maintaining social contact
    - Follow up communications
        - Establish a clear and consistent pattern of daily follow-up outbound communications. This will ensure residents, families and stakeholders are informed of developments as they unfold.
        - OPAN can assist with communications with residents and families if needed
    - Continue primary health care
        - Ensure there is strong ongoing governance of "routine" care. Understand residents will be anxious and need reassurance.
        - Notify residents' GPs who may contribute to monitoring, care planning and discussions.

        - Consider governance structure to maintain and monitor normal activities as far as possible. This includes nutrition, physical activity, and preventing boredom, loneliness and unhappiness. Additional psychological care may be required.
- Support your staff
- Continue to monitor state/territory guidelines

Appendix 2 - Commonwealth and NSW protocol to help manage a COVID-19 outbreak in a residential aged care facility in NSW[82]

[Notes]

- The key principles underpinning this protocol are:
  - All Australians should be able to access healthcare and live with dignity, regardless of their age and where they live.
  - Consumer-centred care
    - The clinical and welfare needs of residents are paramount. Decisions on the most appropriate clinical care, including location of the care and whether transfer to hospital is required, are made in consultation with clinical care staff and residents (and their representatives). Decisions are regularly reviewed, and made on an individual basis, but also take into account the safety and welfare needs of all residents and staff in the RACF.
    - RACF residents continue, as do other people in the community, to have a right to access public health services (including hospital) based on their clinically assessed need.
    - Risks to individuals, and the service, take into account, needs and preferences of each resident and their representative (including through advanced care plans), and the circumstances of the RACF at which they reside.
    - Communication to residents and their representatives is coordinated by the provider and occurs as frequently as indicated by the changing profile of the outbreak and the communication preferences of the RACF residents and their representatives.
- Roles & responsibilities
  - Commonwealth Department of Health
    - Facilitate adequate access to primary care for residents of the RACF.
    - Facilitate access to resources, including surge workforce (where required) and personal protective equipment (PPE).
    - Facilitate relocation of cohorts, where appropriate. Provides rapid response COVID-19 in-reach pathology testing services, if required.
  - Aged care approved provider
    - Develop and maintain an OMP to ensure preparedness in the event of the outbreak including engagement with Local Health District.
    - Lead and manage implementation of the OMP in response to the outbreak in the RACF
    - Notify and liaise with the local Public Health Unit (PHU), and the Commonwealth Department of Health.
    - Establish an Outbreak Management Team in conjunction with the PHU (immediately) and co-chair daily meetings of the Outbreak Management Team until the outbreak is closed.
    - Contingency planning in the event of significant staff loss (30-40 per cent)
    - Implement a timely and responsive COVID-19 communication policy with residents and their families.
    - Work with GPs to review/develop advance care plans for residents.
    - In coordination with the Senior Inter-governmental Oversight Group, liaise with GPs and allied health personnel to ensure approach to acute and chronic disease is addressed,

[82] https://www.health.gov.au/resources/publications/commonwealth-and-nsw-protocol-to-help-manage-a-covid-19-outbreak-in-a-residential-aged-care-facility-in-nsw

and de-conditioning, grief, cognitive decline and psychiatric sequelae of isolation and loss are addressed.

- Local Public Health Unit
  - Lead the public health response and support the RACF in executing its role.
  - Ensure that public health and initial infection control measures are implemented to control the outbreak. If barriers are identified that cannot be resolved locally, escalate to Senior Inter-governmental Oversight Group to ensure appropriate resourcing and outcomes.
  - Where the PHU has limited capacity to respond, the PHU should discuss surge support with PHEOC
- Local Health District
  - Establish clinical outreach team, infection control and testing requirements.
  - Work collaboratively with residents' usual general practitioners, and other treating specialists, as is usual practice.
  - Determine clinical lead and outreach model (Hospital in the Home /geriatric outreach model) with specialist clinician support (e.g. geriatrics, infectious diseases, palliative care) to maximise clinical care of residents both COVID-19 positive and negative.
  - In partnership with the Clinical Excellence Commission, advise on infection prevention and control measures, including isolating and cohorting residents (for both COVID-19 positive and negative residents), with support for monitoring as needed.
  - Determine, through the LHD Clinical Governance mechanisms, the level and type of specialist and support care required (for example, infectious disease, palliative care, geriatrics, allied health). Assist the RACF in testing of all residents and staff.
  - Support staff/GPs to support appropriate patient-centred care and review/develop advance care plans for residents.
  - Liaise regularly and provides clinical information and support to GPs, NPs and allied health professionals where indicated.
  - Determine the processes for clinical deterioration, including care in RACF and/or support to transfer to hospital as clinically determined and consistent with the wishes of the resident.

- Trigger events requiring escalation to the Senior Inter-governmental Oversight Group:
  - Rapid deterioration of the situation
  - The provider does not demonstrate capability to effectively lead and manage the outbreak response
  - The RACF premises are unsuitable to manage the outbreak effectively
  - The Local Health District does not have capacity to provide a clinical outreach response
  - Any other issue impacting on the effective management of the outbreak.
- Governance Structures
  - Outbreak Management Team – does not include GPs

Appendix 3 - COVID outbreak governance – residential aged care facilities[83]

[Notes]

- Residential Aged Care Facility
  - Work with PHU, primary care and Clinical Outreach services to manage outbreak and provide care for residents
  - Ensure ongoing care needs are maintained, including liaison with GP and allied health personnel.
- Local Health Districts
  - PHU – lead the public health response and support the RACF in executing its role
  - Clinical Outreach Teams
    - provide clinical support through HITH/Geriatric outreach models, including specialist clinical advice and management (geriatrics, infectious diseases, palliative care).
    - Support GP and RACF staff to develop ACP planning for residents
    - Provide clinical information to treating GPs
    - Determine processes for clinical deterioration: care in RACF/transfer to hospital
- Department of Health
  - Ensure viability and capacity of service provider to manage outbreak
  - Meet funding cost of managing the outbreak
  - Implement and embed critical response team if provider response not viable
  - Facilitate access to surge workforce (Mable, Aspen Medical), PPE
  - Facilitate relocation of cohorts where appropriate

[83] https://www.health.nsw.gov.au/Infectious/covid-19/Documents/racf-outbreak-roles.pdf

Appendix 4 - NSW Incident Action Plan for a public health response to a confirmed case of COVID-19 in an Aged Care Facility[84]

[Notes]

- Principles
  - Maintain the clinical and welfare needs of the residents as a priority. Primary health care needs remain of high importance to maintain health in a frail population. Engage clinicians within the ACF if access to usual supports are limited
- Outbreak Management Team (OMT)
  - [does not include GPs]
- Tasks of the Outbreak management Team
  - Resident welfare and appropriate management of cases is maintained by the clinical teams, including virtual care service, HITH, Allied Health, Nursing and General Practice. The ACF Clinical Lead will coordinate this process.
  - Ensure regular medical needs are addressed for all residents. Consideration should be given to engagement of general practitioners and other allied health practitioners to address these requirements. Establish communication arrangements with residents' usual GPs
- Process
  - If the case is a resident, the ACF should isolate the case in a single room with a private ensuite. If not available, alternative accommodation arrangements are required.
  - Where possible, key response personnel undertake a site visit (for example, PHU +/- PHRB, clinical and infection prevention and control (IPC) staff) to enable assessment of facility layout (understanding pathways of infection, cohorting possibilities), personnel and roles, standards of infection prevention and control, etc.
  - If the ACF is unable to isolate cases or contacts appropriately, such as because of a lack of single rooms, consideration should be given to alternative accommodation (for example, hospital) for residents to enable isolation. This will be a discussion by the OMT, with assessment of capacity for alternative accommodation with the LHD and the SIOG. The decision needs to be balanced with the negative health impacts of moving residents to an alternative facility, the clinical needs of the residents, and the potential ongoing public health risks within the ACF and alternative facility.
  - Residents with COVID-19 should remain in the facility if possible and if this is consistent with their wishes, or in accordance with their Advance Care Directive. The resident should be transferred to hospital if clinically indicated. If any resident needs to be transferred to hospital, the ACF should advise the ambulance and hospital beforehand that the resident is from a facility with a COVID-19 outbreak.
  - Communication: a daily running sheet of decisions and directions determined at the OMT is maintained by the ACF. Public Health Response Branch (PHRB) operations team can assist with this documentation if needed. All verbal advice (for example, given by phone) will be confirmed by email, and tabled at the next OMT meeting. *[cc to GPs??*]
  - Death certification: Any deaths that occur are to be certified by the treating medical team or the resident's general practitioner.

[84] https://www.health.nsw.gov.au/Infectious/covid-19/Documents/racf-incident-plan.pdf

Appendix 5 - Clinical Excellence Commission COVID-19 Outbreak Management Checklist for RACFs[85]

[Notes]

- Recognise potential or suspected outbreak
  - Residents
    - Seek urgent medical review of probable and suspected cases
- Begin collection of preliminary information (Contact Tracing & Outbreak Investigation)
  - Notify
    - Notify GPs of suspected residents included in the outbreak (contact and/or symptomatic) – document in health record
    - Notification to the Primary Health Network (PHN) may be required if other aged care facilities within the PHN
- Restrict
  - Ensure staff and GPs are aware of infection prevention and control guidelines for transferring residents to and from hospital, including isolation requirements for new and returning residents
  - Organise/facilitate Telehealth options for residents with GPs and other health providers

[85] http://cec.health.nsw.gov.au/__data/assets/pdf_file/0012/596586/COVID-19-Outbreak-Management-Checklist-for-Residential-Aged-Care-Facilities.pdf

Appendix 6 – Victorian Experience, Aged Care GP (www.agedcaregp.com)

A group providing GP services to RACFs. Has dealt with 7x RACF COVID-19 clusters. The following are notes from recorded video with advice for GPs by Dr Sachin Patel on dealing with a RACF COVID-19 cluster.

- Telehealth is a given – get it ready and use it as much as possible
    - Overcome RACF IT issues and willingness of RACFs to invest
    - Many residents have their own phone/devices – get those details so you can contact them directly to check on them
- PPE – for GPs and residents
    - Wear full PPE – glove/gown/mask/eye protection – protects you and excludes you from quarantine/close-contact definition
    - If you don't like mask/eye protection, you can wear a ventilated hood (PAPR)
- Have cash reserves in place for 2 weeks of quarantine – perhaps for multiple episodes
- RACF staff
    - PPE/infection control training – reinforce training and drills, remember often low paid and not well trained
    - Test – reinforce very low threshold for testing and isolate as early as possible. Safer Care Victoria has released a handy screening tool/device.
    - Contingency planning – staff decimated in outbreaks – have backup plans
- Outbreak
    - Communication vital
        - SMS & email to family – group info
            - Families will be scared and worries – comm to them, you won't have the time to communicate 1:1. Can use CRM technology, get this in place
        - Many residents have their own phone/devices – get those details so you can contact them directly to check on them
        - Family webinars – can be extremely helpful – answer questions directly, people appreciate it, efficient use of time, may seem scary but it's not.
            - Can also do pre-outbreak webinars to help prepare families! Aged Care GP group is doing a 1000+ family webinar for this
- End of life planning
    - Obviously important and good to do ahead of time
- Local liaison
    - Close collaboration with colleagues, residential in-reach from hospital etc.
- Peer support
    - This is going to be a really tough time
    - Be in a network where you can share experience and learning
- DHHS
    - Responses have improved a lot since March, but very stretched
    - What they can't deal with:
        - Family liaison & comms
            - Most of GP work will be counselling, reassurance
- When resident needs hospitalization, esp wandering with dementia
    - Discuss with in-reach/hospital
    - If a difficult decision to be made, when difficult/contentious, seek peer support (e.g. "three wise people")

Summary:

- GPs will often find themselves not integral to *medical* outbreak management of COVID19, but remain vitally important esp re: comms to patients and relatives
- Wear Full PPE
- Telehealth continuity is important
- New staff in the event of an outbreak will be challenging
- Comms comms comms – especially to family

Appendix 7 – Victorian Experience, Dr Sachin Patel

Facebook post to the Aged Care group, 1st August 2020

Attention Victorian GPs who provide services to RACFs.

Following discussions with multiple parties, I have been asked to share the following information. This information is current as of 31 July 2020 and will be updated on Wednesday 5th August. The purpose of this communication is to reduce the risks of catastrophic failures in RACFs as have occurred in the past week whilst making efficient use of GP time.

There are 5 key points for GPs in Victoria working in RACFs.

1. Diagnosis and early implementation of strict infection control measures is one of the best ways to minimise the spread. As soon as you become aware of any diagnosis, please have a conversation with the RACF and ensure they have:

a) a plan in place for facility wide testing

b) that they have implemented a strict infection control plan and isolation of residents pending further advice.

c) that they inform their local Residential In Reach/Out Reach service

2. In any RACF that has a current COVID outbreak, if you are concerned about the prospect of a facility being able to continue to cope or manage, this is how escalation is currently proving to be most effective:

Please raise immediately with your local In Reach or Out Reach Service. Currently this has been found to be the most effective way of escalating coalface concerns to the Victorian Command Centre. The failures over the past week have been related to basic care (food, water, personal care) rather than medical need.

3. Workforce preservation of staff in Aged Care is a key priority in battling current and future outbreaks. The Victorian Command Centre is issuing advice and supplying PPE to all RACFs in Melbourne.

All RACF staff in Aged Care with patient contact should now be wearing masks and face shields as an absolute minimum. The hope is that this will avoid prolonged quarantine measures in the event of an outbreak in a facility. And this will allow RACFs to continue to operate with regular staff, supported by temporary staff. When there are wholesale staff changes, this has been found to be a direct contributor to catastrophic failures in basic care.

4. Please complete this survey from NWPHN: https://www.surveymonkey.com/r/5993XDN

Please request facilities to have the following information readily available for each resident: medical summary including medications, advance care directive, recent picture, family contact details and GP details.

5. We want to convene as many GPs working in RACFs as possible for an online meeting on Wednesday evening (around 8pm 5/8/2020). The Victorian Command Centre will have clear messaging prepared by then to guide GPs in the best way we can contribute to the effort. Please keep this time available and details will follow and share with any GPs you know attending RACFs.

Appendix 8 - Victorian Experience, Dr Bernard Shiu

Personal communication to Dr Fiona Van Leuwen, 9th August 2020

Thank you for your email and it is certainly a very stressful time for all of us. Victoria has been preparing for this 'second wave' since the absentee first wave that did or did not hit us. I guess we never knew if we were really ready until we were put to the test. Well now we know!! When the dragged phone call came, that email arrived, or that result of a positive COVID19 showed up in our inbox, then, only then we realised how unprepared we were.

Over the past few months, both in metro Melbourne and regional cities, we have learned lots from each outbreak. There is no one has more experience as a GP in dealing with RACF outbreak than Dr Sachin Patel. Sachin runs a GP service solely provide care to nursing homes. From Feb to now, he has dealt with 7 outbreaks working with DHHS. Many of the protocols we have currently are from the lessons he learned and the experiences he shared with us.

In Geelong, fortunately we have a great team of GPs who are dedicated, smart and super caring for all the RACF residents. A small group of us who are keen and have been looking after RACF for many years, decided to form a collaboration to try to coordinate the effort a bit better. This collaboration was born out of the realisation of a lack of coordinated approach within the region and how overwhelming it has been for those involved for the first outbreak in one of our facilities.

Some of the key things we have learned from the last few weeks:

- Communicate communicate and over communicate is the key
- We set up weekly huddles for small groups and large group updates for all parties to be brought up to date https://westvicphn.com.au/health-professionals/health-topics/digital-health/project-echo-covid19/
- We have a Telegram group for all the GPs in the region and can disseminate information almost instantly
- a separate Telegram group was setup specifically for RACF
- We share useful protocols, letters, guidelines via Telegram so everyone stays on the same page and have access to the latest updates and approach
- Work with the local PHN, Barwon Health, ID, Geriatricians, ED, Ambo and nearby GP clinics to have an understanding what to do before, during and after an outbreak
- Personalise and put planning and strategy in place for each facilities with realistic and actionable items that are tailor-made for them
- Assign a clinical champion (GP) to each facility to co-ordinate communication between clinicians, nursing staffs, admin, DHHS and families
- Advanced care planning and frank discussion with families before any outbreak to align expectation and possible outcome
- Lots of red tapes between different agencies and governing bodies, pre-historic legislation restriction will hamper even the most well thought out plans. I suggest to get your local MPs involved
- DHHS is super slow in responding to crisis, thankfully the RACGP pushed hard for some of the changes e.g. the newly announced DHHS reporting phone line with a call back feature etc which significantly reduced the time wasted to wait for someone to answer the phone from DHHS for us to report a case

- Nurses, GPs, allied health and admin staffs are doing their best. They are also human and have their emotional and physical limits, so be mindful of their needs
- Many if not most RACFs are supported by agency nurses and a large number of visiting GPs, causing major communication and commitment issues
- Nurses and doctors can fall ill too, and they also need to be looked after
- PPE, well, you know the drills, needs lots and lots and lots of it, with training and testing and then more training and testing. It only takes one breach and the whole facility can be infected
- Talking about drills - run simulation before the real thing so everyone knows who to call, where the masks are and how to lock down the facility etc
- document findings and learning points and share with the group

Appendix 9 - Victorian Experience, Dr Gaveen Jayarajan

Facebook post, Aged Care group, 22/7/20

Covid-19 Disaster Planning - It's Here. Now What Do We Do?!

I had a conversation recently with a doctor involved in an RACF Covid outbreak. This is what I've learned from them so far and also my take on it...

- Sending the index case (if it's a patient) to hospital early may have benefits in reducing spread to others and protecting others
- Make sure all residents/staff get tested early after the index case is identified and get their results back soon (this is in DHHS control, but it's worth noting in case there are notable delays in this process)
- Isolation in rooms or wings or wards is very, very hard in the RACF setting
- Usual staff/carers may need to be isolated due to being close contacts and this may impact care, in addition to restrictions on family visits
- Elderly maybe asymptommatic initially but may then deteriorate later very rapidly eg. within 24 hours
- Speak to all family members now about advanced care planning/goals of care in the context of Covid (even if they have an existing one already, review them now in the context of Covid)
- Explain that hospitals will not have capacity to take all patients in the context of a Covid outbreak
- For those who are not for CPR/intubation, and particularly with dementia, most of the treatments likely to be offered in hospital can be offered at the RACF (assuming no other concurrent medical issues)
- These treatments can be oxygen, subcut fluids, oral or IM abs if indicated, maybe dexamethasone if hypoxic (if side effects can be tolerated) and maybe clexane. That's about it...
- If they deteriorate despite this then they will likely be for palliative care
- Explain that going to hospital is generally not going to change this
- IV fluids and IV antibiotics won't necessarily be appropriate in some patients with dementia who may pull cannulas out, as well as oxygen via nasal prongs/masks
- They may also get delirium in hospital
- Get a feel for who will really want their family member to go to hospital regardless of the above, and who will be happy to stay
- Ensure anticipatory end of life medications are charted for all residents if there is a Covid outbreak (or prior to one)
- Check in on your patients regularly during a Covid outbreak (eg. through Telehealth) and continue to attend to non-Covid matters that the RACF still need you for
- Maintain regular family communication during a Covid outbreak, either in bulk through email or SMS, and/or through direct phone calls
- Now may not be the time to worry about MBS rebates for your work and some unpaid work maybe in order (my opinion)
- Even if you are predominately doing Telehealth, there may come a time where you need to go in to help, as hospital in-reach services and DHHS may not necessarily have the manpower to do this from a clinical point of view, particularly if there are multiple outbreaks in a catchment... (my opinion)
- Consider involving your private Geriatricians to help particularly where they are accessible/available and in-reach services are at capacity - is there a role for a public-private partnership here?? (my thoughts) TJ Ong, Christine Mandrawa, Mya Tun
- Have your PPE ready and protect yourself, and your family when you get home with appropriate precautions (plan your Covid wing and process at home!)

Appendix 10 – International experience re: COVID-19 & RACFs

- Italy[86]
  - Authorities in Milan are probing one of the largest care homes — Pio Albergo Trivulzio — where 190 residents out of 1,000 are believed to have died of the illness.
  - "This pandemic has shone a spotlight on the overlooked and undervalued corners of our society. Across the European region, long-term care has often been notoriously neglected," said Dr. Hans Henri P. Kluge, WHO Regional Director for Europe, in a statement on April 23, as he urged more protective gear, training and medical supplies to prepare for another wave or pandemic.
  - "We were not ready. I must absolutely recognize that," Professor Raffaele Antonelli Incalzi, president of the Italian Society of Gerontology and Geriatrics, told MarketWatch in a recent interview.
  - Among the first errors made in Italy were a lag in imposing strict measures, such as limits on visitations, and lack of testing as not all symptoms were the same, he said. "We were convinced that fever and cough were the presenting symptoms and actually they are in the vast proportion, but some complained of headache, fatigue, diarrhea and so on. It's absolutely necessary to have a high degree of suspicion," Incalzi said.
  - They also learned that using nursing homes as convalescent facilities for people discharged from hospitals and recuperating from the virus was a costly mistake. Kluge has also urged the isolation of cases via separate wards or spaces for residents with the virus.
  - "This was a terrible error in Northern Italy and Lombardy ... many of these people were not completely healed, they were still infected with COVID and that accounted for the spreading of the disease in a very frail population," he said, adding that it's "mandatory to avoid such a strategy."
  - In Italy, one big step toward trying to prepare for the next outbreak has been taken at the behest of Incalzi and his colleagues via the GeroCovid Observational Study, an electronic registry of 60 nursing homes in Italy and their affected patients.
- Spain[87]
  - Jesús Cubero, the president of the Spanish association of senior care homes, Aeste, complained that a lack of protective equipment was a problem in the early days. He added that of Spain's 5,400 or so elder care facilities — 75% private and 25% public run — the larger ones often fared better.
  - "The biggest problems were in small companies and those run by religious structures, which were less professional as they had lots of volunteers, which is normally OK," he told MarketWatch. "But with big companies you can manage with workers going from one place to another. If you have a lot of workers you can manage better."
  - One complaint of Spanish geriatric doctors was that few patients 80 or older were admitted to ICU compared with younger patients and they have asked the government to try to equip care homes better to confront the next wave of the virus.
- France[88]

[86] https://www.marketwatch.com/story/coronavirus-was-devastating-europes-nursing-homes-well-before-the-us-here-are-the-lessons-they-learned-2020-05-07

[87] https://www.marketwatch.com/story/coronavirus-was-devastating-europes-nursing-homes-well-before-the-us-here-are-the-lessons-they-learned-2020-05-07

[88] https://www.usnews.com/news/world/articles/2020-04-17/french-nursing-home-learns-costly-lessons-on-containing-coronavirus

- When managers at La Riviera nursing home on France's Cote D'Azur found out a resident had the COVID-19 virus, they put into action a standard playbook they believed would contain the spread. It did not. Since then 36 residents at the home have died of coronavirus-related conditions, according to the local mayor's office, which registers the deaths. There were 109 residents before the coronavirus crisis broke.
- The authority has said the home's managers waited too long to seek help. The home's operator, Korian SA, said its staff acted in line with official guidance, and sought help when it was necessary. The first case at the home was identified on March 15, when a local hospital treating a resident informed the home that the person had tested positive for COVID. Ruplinger, the executive with the home's operator, received a call about the case just before midnight. The next morning, he arrived at La Riviera. He ordered that staff were to wear protective gear at all times, cleaning was to be stepped up and residents were to be confined to their rooms. Residents suspected of having the virus were moved to an 11-bed unit on a separate floor. Within three days of opening, the segregation unit had run out of beds.
- What happened at La Riviera underlines the potential value of blanket testing at an early stage, some French officials said. "Maybe if we had been able to test from the beginning, everything would have been different," said Florence Arnaiz-Maumé, an official with the National Union of Private Homes and Facilities for the Elderly (SYNERPA).
- The response by staff at La Riviera was centred around checking who was showing symptoms of infection and isolating them from the rest of the home. That was in line with national guidelines at the time, which were for only the first three suspected cases to be tested. But for over two weeks after the first case, residents in the home were not tested for COVID-19. That meant people who had the virus yet showed no symptoms were still part of the general population in the home and potentially transmitting infection. Twenty days after the first case, systematic testing of residents for COVID-19 began at La Riviera on April 4. Thirty-three residents were found to be carrying the virus, as well as 14 staff, who were sent home.
- The testing allowed the home to put in place a new virus containment plan, guided by an infectious disease specialist from a nearby hospital. Those who tested positive have been put on the first and second floors of the complex. They are cared for by staff who do not mix with other patients, and who use their own dedicated elevator, changing rooms and break rooms. Engineers have visited to make sure there is negative pressure inside rooms with coronavirus patients, so when a door is opened, air does not stream out, spreading the infection.

- United Kingdom[89]
  - UK's Black Swan Care Group, which operates 20 aged care homes across East Britain, 2 had COVID outbreaks as of April 7 2020
  - Across the two homes that have COVID-19 infections, 37 residents have tested positive, three have died, three are in hospital and three are at a palliative stage. And one staff member is in critical care. 15% of the staff have self-isolated on sick leave and are 'scared'.
  - Before the outbreaks they had implemented 'no visitors'. Following guidelines, PPEs were not used, and fresh stocks were not generally available. The infection in one home came from a resident returning from hospital who was isolated for seven days after being brought to the home as per the Government's guidelines. On the eight day, they showed symptoms. The infection in the second home was transmitted by a staff member returning from a trip

[89] https://www.theweeklysource.com.au/real-lessons-from-the-uk-frontline/

to Spain with no symptoms and before testing protocols had been put in place. They were on night roster and had visited multiple resident rooms. Infections in this home went from 0 to 20 in three days, and then one to two a day.

- The immediate impact was: "you can't get staff and you can't share staff". Following the outbreak, no doctors were prepared to visit the homes for 10 days and no one could be tested. The lack of hospital beds mean that residents who had advanced UTIs and falls were deemed to be unsuitable for admission by paramedics – leaving them in the home. External nurses also refused to attend, resulting in residents missing medications such as insulin. Agency staff refused to work in infected homes. The phones were 'inundated'.
- The first 48 hours after the infection is critical for motivation. Staff are scared and greatly impacted by the media, especially social media. A significant minority stated 'they did not sign up for this' and 'can easily get home care jobs for the same money around the corner', and without risking their family. With the 15% self-isolating, the remaining staff are working double shifts. Some floor staff and regional management are self-isolating, dispatching their families to other relatives. The leadership team is concerned about this given the potential length of the pandemic. Communication, constant reassurance and motivation by the leadership is vital. 5am phone calls to the homes, making sure each employee's name is known in the conversation, plus attendance on the floor seven days a week out of hours, bringing chocolates etc to add to the atmosphere. Staff want to wear PPE all the time – which is not possible. They also believe there should be no new admissions. Explanation of the financials is delicate. Morale is damaged by lack of recognition of care workers compared to the high public recognition given to NHS workers.
- Staff need constant explanation that PPE are not available and the guidelines limit their use.
- Each home was allocated 300 masks per week. No other PPE is available. Black Swan purchased 4,000 bin liners as aprons. Face visors "were impossible" to secure so they use goggles, which they disinfect after each use. They were paying 8 pence a year ago for masks and 29 pence just before the pandemic. Other operators who had not prepared supply are now paying £2.60 for a mask that can be worn for just one hour. Families are demanding to know why staff are not wearing masks all the time.
- 80% of families are okay and 20% are "beyond scared and extremely worried". It is surprising that families have NOT taken people out of the homes. However, they have had no new private admissions, with occupancy halving in the infected homes. Family volunteers have been really positive; and difficult family members have been advised they should consider volunteering.
- Their 'worry' is that hospitals will send them infected palliative patients to die and they do not have PPE. Hospitals are being disingenuous in who they send to the homes. Staff are sent back to the hospitals to check records and are discovering that some hospitals have 'lied', resulting in the resident being sent back to the hospital. One patient delivered by the hospital, it was discovered, had been received by the hospital from jail because he had stabbed his wife. The home had not been given this information. Another hospital transfer had had their medical records altered.
- Costs have escalated, (plus the minimum wage has gone up 6%). A significant number of providers will run out of cash in the next two to three months. Less financially secure operators are taking high-risk clients to maintain cash flow and fill vacancies. These operators are having to resort to supermarkets to supply food and groceries – with order fulfilments significantly incomplete.
- What would you do if you had your time over? Ensure a plentiful supply of PPE so staff feel safe to come to work. 'Manage the message'. To counter what is in the media, particularly

around the perceived security against infection that PPE deliver, which panics staff. Get the government to deliver cash. Get the government to value 'social care workers'. Reassure staff about what things will look like in three months' time (positive).

- United States of America[90,91,92]
    - As of August 13, COVID-19 has infected more than 402,000 people at some 17,000 facilities, resulting in at least 68,000 deaths amongst residents and workers.
    - American nursing homes are chronically short-staffed and, even prior to the pandemic, were doing a poor job of controlling infections. Well into the crisis, these facilities were short of masks, tests, and other necessary equipment.
    - in the U.S., some experts say that staffing shortages have made nursing homes unprepared to deal with a pandemic. One recent study that examined nursing-home data in Connecticut found that long-term-care facilities with lower nurse-staffing levels had higher rates of confirmed COVID-19 cases and deaths.
    - Grabowski and other experts have also noted that nursing-home staffers tend to make little money, so many work multiple jobs. That creates an environment in which busy, undertrained personnel are shuffling quickly between patient rooms and nursing homes, taking the virus with them.
    - In June, a House subcommittee tasked with overseeing the country's response to the coronavirus wrote a letter to the largest American nursing-home companies, and to the Centers for Medicare and Medicaid Services, which regulates nursing homes; nationally, such facilities, the letter pointed out, still lack enough tests to meet the federal government's recommendation that nursing homes test all residents and staff weekly. And then there's the issue of masks, which are considered another crucial element of stopping the spread of the coronavirus in nursing homes and elsewhere. Guidance on masks from CMS came much too late, Sloan said. According to a recent Reuters investigation, some nursing-home managers initially discouraged staff from wearing masks because they thought they wouldn't help prevent infections.
    - Unlike those in Hong Kong, American nursing homes didn't have months of masks stocked up. When the virus hit, they utilised their supplies at hundreds of times the rate they normally would. Hospitals, not nursing homes, were seen as the priority destination for the country's reserves of masks. "We somehow expect individual nursing-home operators to compete against large hospitals and states in trying to get that equipment," Konetzka said. Perhaps expectedly, months into the pandemic, many nursing homes ran out of masks and gowns. In early June, federal data showed that more than 250 nursing homes had no surgical masks and 800 more were a week away from running out.
    - To make matters worse, nursing homes across the U.S. took in COVID-19 patients from hospitals. In Minnesota, 77 percent of COVID-19 deaths have taken place in nursing homes, according to the Kaiser Family Foundation. Despite this, Minnesota hospitals discharged dozens of COVID-19 patients to nursing homes, the Minneapolis Star Tribune reported in May. "Hospitals were running out of space," Sloan said. "And so they were transferring people to nursing homes. And our nursing homes were saying, 'You can't give us people who have COVID unless you give us PPE.'"

[90] https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html
[91] https://www.theatlantic.com/health/archive/2020/07/us-repeating-deadliest-pandemic-mistake-nursing-home-deaths/613855/
[92] https://www.washingtonpost.com/health/covid-19-surges-back-into-nursing-homes-in-coronavirus-hot-spots/2020/08/13/edbff5fe-dd75-11ea-b205-ff838e15a9a6_story.html

- one of the strongest correlates of whether nursing homes experience outbreaks is whether the surrounding community has lots of COVID-19 cases. Some experts say the best way to stop coronavirus outbreaks inside nursing homes, then, is to stop them outside of nursing homes first. The problem in the early days of the pandemic was the unrecognised lethality and transmissibility of the virus. But long-term care facilities today face a threat from the sheer amount of coronavirus in the community surrounding them.
- Another recent study found that nursing homes with larger staffs were better able to limit outbreaks when they occur. Usually, this is done by separating infected and uninfected residents and stepping up other infection control measures

- Hong Kong
  - Early reports – first/second wave[93,94]
    - Hong Kong, population 7.5 million, which has reported no deaths from COVID-19 in its care homes *[as of July 6 2020]*. The city was scarred by the outbreak of severe acute respiratory syndrome, or SARS, in 2003, during which it suffered nearly 300 deaths, or almost 40 percent of the global death toll. Nursing-home residents were more likely than the general public to get SARS, and 78 percent of residents who got the virus died from it, according to Terry Lum, the head of the department of social work and social administration at the University of Hong Kong. "We also had a few doctors and nurses get killed by SARS," Lum told me. "Those are painful to watch. We didn't want to see that ever again."
    - Immediately after the 2003 outbreak, the Hong Kong government launched a revamped policy of infectious-disease control that required nursing homes to have a designated, government-trained infection-control officer, with infection outbreak drills four times a year so infection control becomes "a well-worn practice". All nursing homes had to maintain at least a month's supply of face masks and other PPE.
    - Once an infected person is identified, they are isolated in hospital for three months and at the same time all the close contact people are isolated in a separate quarantine centre for 14 days for observation
    - As soon as COVID-19 broke out in Hong Kong, in January of this year, its nursing homes halted nonurgent hospital trips among residents as well as family visitation, Lum said. Nursing-home staffers donned masks as they cared for the residents. Any nursing-home residents who caught COVID-19 were isolated in hospital coronavirus wards—not in nursing homes—until they had tested negative for the virus at least twice.
    - There was a human cost to the lack of family visits, Lum told me; patients who had dementia deteriorated more quickly without social interaction. But nursing-home administrators were certain that if even one COVID-19 case snuck into a nursing home, it would spark a conflagration with tragic results.

[93] https://www.theatlantic.com/health/archive/2020/07/us-repeating-deadliest-pandemic-mistake-nursing-home-deaths/613855/
[94] https://www.theguardian.com/world/2020/may/19/mps-hear-why-hong-kong-had-no-covid-19-care-home-deaths

- Later reports – third wave[95,96,97]
  - Hong Kong government guidelines for care homes have been tightened after the city saw its first Covid-19 outbreak in a facility for the elderly, but medical experts are calling for the suggestions to be made mandatory to truly protect some of society's most vulnerable. The updates to the Centre for Health Protection's guidelines on Wednesday came as the number of residents and staff infected at the Kong Tai Care for the Aged Centre Limited in Tsz Wan Shan rose to 32. At least one staff member confirmed to have Covid-19 worked at another facility run by the same operator on a higher floor in the same building. Previously, the city had managed to keep the virus out of facilities for the elderly , a problem that has plagued other countries such as the United States. The revised guidelines state such homes should "avoid as far as possible deploying staff to work in different residential care homes", while people living there should avoid leaving "unless deemed necessary". But Kenneth Chan Chi-yuk, chairman of the Elderly Services Association of Hong Kong, said following the guidelines was not always possible. "If you stop such a practice, who can fill those vacancies? Employers hope to meet the CHP's recommendations, but in reality, whether they are able to do so is another issue," he said.
  - Hospital Authority chief executive Dr Tony Ko Pat-sing wrote in a blog post on Friday that hospital officials were "very worried" about the latest wave of infections. While there are quite a lot of community outbreaks that cannot be traced, our isolation facilities will soon be full," Ko said. He said community isolation facilities for Covid-19 patients who were stable or asymptomatic would need to be activated when isolation beds in public hospitals were full.
  - Dr Chuang Shuk-kwan, head of the communicable disease branch of the Centre for Health Protection, said one of the confirmed cases was a personal carer who accompanied elderly residents from care homes to medical consultations. So far, all patients confirmed with the coronavirus had been treated in public hospitals, where there were 1,200 first-tier and 500 second-tier beds.
  - Affected Hong Kong RACFs as of 15th August 2020[98,99]
    - Kong Tai Care for the Aged Centre, 46
    - The Salvation Army Lung Hang Residence For Senior Citizens, 15
    - Cornwall Elderly's Home (Golden Branch), Tuen Mun, 40
    - Sham Shui Po King Fok Nursing Home, 14
    - SAGE Kai Yip Home for the Elderly, Kowloon Bay, <10
    - TWGHs Jockey Club Sunshine Complex for the Elderly, <10

[95] https://www.scmp.com/news/hong-kong/health-environment/article/3092571/coronavirus-guidelines-keep-hong-kong-elderly

[96] https://www.scmp.com/news/hong-kong/health-environment/article/3092289/coronavirus-hong-kong-has-another-14-cases-covid

[97] https://www.scmp.com/news/hong-kong/health-environment/article/3096588/more-elderly-people-will-die-grim-facts-behind

[98] https://www.chp.gov.hk/files/pdf/local_situation_covid19_en.pdf

[99] https://wars.vote4.hk/en/cases

        - Siu Sin Nursing Centre, <10
    - "*Almost 90% of Covid-19 deaths in Hong Kong happened in the past month as the outbreak entered nursing and elderly care homes -- 48 deaths as of Monday, seven times the toll of the entire first half of the year.*" [100] 11th August 2020
    - "*Around 20 care homes, including those for the elderly and the disabled, have reported Covid-19 infections. Four homes accounted for 17 deaths, including nine linked to the Kong Tai Care for the Aged Centre Limited in Tsz Wan Shan and six from Cornwall Elderly's Home (Golden Branch) in Tuen Mun. Deaths from elderly care homes made up more than a third of all Covid-19 deaths so far*".[101] 9th August 2020
- South Korea[102]
    - 19 March 2020
        - New clusters of infection have emerged in South Korean nursing homes, complicating the country's fight against the Covid-19 outbreak, as experts warn that hundreds of substandard long-term care facilities could serve as hotbeds for the contagious coronavirus.
        - More than 200 cases have been reported in these senior-care facilities, mirroring outbreaks reported in Italy and parts of the United States, such as the states of Washington and Florida.
        - Many nursing homes, which provide long-term residential care for elderly or disabled people, accommodate patients and untrained carers in small spaces. These facilities are often understaffed, with just one or two medical doctors assigned.
        - The largest cluster involving a nursing home occurred at Hansarang Care Hospital in the same city, where 75 people were infected.
        - Another major cluster was found at Pureun Nursing Home in Bonghwa County, 114km north of Daegu, where 64 people were infected. Of that total, 56 were patients, while the others were staff members and carers.
        - As of Thursday, at least 238 cases of infection were confirmed at 10 nursing homes in Daegu and North Gyeongsang province, according to Daegu authorities.
        - "Nursing homes are especially vulnerable to infection as many of them have substandard facilities and a multiple number of elderly patients with chronic diseases are housed in a room," said Lee Hoan-jong, emeritus professor at Seoul National University.
        - Said Kim from the Korean Society of Epidemiology: "The virus might have been spread by visitors, carers or hospital staff. No one can be sure until tracking is completed … Many carers at such facilities have little understanding about disinfection and hygiene."

[100] https://www.bloombergquint.com/onweb/hong-kong-sees-fewest-virus-cases-since-start-of-latest-outbreak
[101] https://www.msn.com/en-sg/news/world/more-elderly-people-will-die-grim-facts-behind-hong-kong-s-covid-19-death-surge/ar-BB17JZiy
[102] https://www.scmp.com/week-asia/health-environment/article/3075937/coronavirus-nursing-homes-emerge-south-koreas-new

Appendix 11 – Goals of Care Document – Barwon Health

GOALS OF CARE AND DETERIORATION MANAGEMENT – RESIDENTIAL AGED CARE

PATIENT LABEL REQUIRED HERE

1a. ADVANCE CARE DIRECTIVE (ACD)

Does resident have an ACD?
☐ Yes: Ensure copy is in an accessible location ☐ No

b. ADVANCE STATEMENT (Mental Health Act 2014)

Does resident have an Advance Statement?
☐ Yes: Ensure copy is in an accessible location ☐ No

2. IDENTIFIED MEDICAL TREATMENT DECISION MAKER (MTDM)

Name: ..... Contact number: .....

Relationship to resident: .....

If there is no legally appointed MTDM, refer to Consent for Medical Investigations, Procedures, Treatment & Advance Care Directives procedure

3. CAPACITY TO CONSENT TO TREATMENT DECISIONS

Is the resident able to understand and retain information? ☐ Yes ☐ No
Is the resident able to communicate a decision based on benefits and risks? ☐ Yes ☐ No
Is the resident able to understand the consequences of decisions made? ☐ Yes ☐ No

If no to any of the above, where there is an instructional ACD, this must be enacted. If no instructional ACD, the identified MTDM is required for a goals of care discussion

4. IDENTIFY INDICATIONS FOR GOALS OF CARE DISCUSSION

Clinician initiated ☐ Yes ☐ No
Resident/ MTDM initiated ☐ Yes ☐ No
Life Limiting Illness (see below) ☐ Yes ☐ No

If no to all, proceed to Section 6. Medical advice and shared decision plan

Life Limiting Illness criteria:
Cancer: Metastatic or not amendable to treatment
Functional decline
- Dementia, no consistent meaningful conversation *or* needs assistance with activities of daily living
- Clinical Frailty Score 6-8

Organ failure
- Congestive cardiac failure – NYHA stage III/ IV *or* reduced exercise tolerance
- COPD – disease assessed as severe e.g. long term oxygen therapy/ home oxygen *or* SOB at 100m on level ground *or* FEV1 <30% predicted
- Renal failure – stage 5 chronic renal failure, long term dialysis *or* not for dialysis *or* eGFR <15ml/ min

Neurological disease
- Stroke – minimal conscious state *or* dense hemiparesis
- Parkinson's disease – assistance with ADL *or* falls *or* difficulty swallowing
- Multiple sclerosis – dysphagia
- Motor Neurone Disease – rapid decline *or* episode of aspiration pneumonia

GOALS OF CARE AND DETERIORATION MANAGEMENT

GOALS OF CARE AND DETERIORATION MANAGEMENT – RESIDENTIAL AGED CARE

PATIENT LABEL REQUIRED HERE

5. GOALS OF CARE DISCUSSION (Allied Health, Nursing, Medical)

Refer to existing ACD. If no ACD or ACD not current, refer to Advance Care Planning Program

What are your values and goals? What matters most to you in your life?
(What does living well mean to you? E.g. family, friends, independence, self-care, quality vs living longer, spiritual, religious or cultural requirements, preferred place of care)

What are the unacceptable outcomes for you after illness or injury?
(E.g. loss of independence or not being able to recognise people or communicate)

Clinician Name: …… Designation: ……

Clinician Signature …… Date: ……/……/……Time:……..

6. MEDICAL ADVICE AND SHARED DECISION PLAN (Medical staff only)

Medical advice:

Shared decision plan:

7. CARE IN THE EVENT OF DETERIORATION (Medical staff only)

☐ **ICU Care**

(Treatment aimed at cure or restoration of function)

☐ **Not for CPR**

Specific considerations:
……
……
……

Transfer to hospital if indicated

☐ **Acute Ward Care**

(Treatment aimed at supporting recovery)

Not for CPR or ICU

Specific considerations:
……
……
……
……

Transfer to hospital if indicated

☐ **Residential Facility Care**

Not for CPR

☐ Treatment of reversible illness at the facility.

☐ Not for life prolonging treatment of new illness. Commence palliative care plan

Specific considerations:
……
……

Not for transfer to hospital unless symptoms cannot be managed in the facility e.g. fracture

☐ **End of Life Care**

(Prognosis assessed as hours/ days)

Commence Palliative Care Plan.

Specific considerations:
……
……

Not for transfer to hospital unless symptoms cannot be managed in the facility e.g. fracture

Resident/ MTDM name:…… Resident/ MTDM signature: ……
Doctor's Name: …… Designation: ……
Doctor's Signature …… Date: ……/……/……Time:……..

Goals of Care form reviewed (date)……/…../….. Resident/ MTDM signature: ……
Doctor's Name: …… Designation: ……
Doctor's Signature …… Date: ……/……/……Time:……..

Version 19/8/2020

Appendix 12 – Goals of Care Document – Northern Health

Residential Aged Care Facility
GOALS OF CARE
Medical Treatment Orders

Facility: Facebook
Address: Doctors in Aged Care

AFFIX IDENTIFICATION LABEL HERE

U.R. NUMBER: _____
SURNAME: Diac
GIVEN NAME: John
DATE OF BIRTH: 21 / 08 / 1920 SEX: M

TO BE COMPLETED BY DOCTORS ONLY

Main health problems: Dementia, CCF

Advance Care Directive / Advance Care Planning document for this Resident? ☑ No ☐ Yes *(ensure copy in Resident's file)*

Medical Treatment Decision Maker (MTDM) if patient lacks capacity to make medical decisions

Name Gaveen Jayarajan Relationship to Resident Son Phone No: [redacted]

Has the MTDM been appointed by the Resident? ☐ No ☑ Yes *(ensure copy of document in Resident's file)*

Identify the appointment: ☑ MTDM ☐ MEPOA ☐ Enduring Guardian ☐ EPOA Personal ☐ VCAT Guardian

Choose ONE option from A, B, C or D --- Add further comments when required.
If UNSURE about goals, or treatment decisions, contact the GP or Residential In-Reach for advice.

RACF - GOALS OF CARE

MEDICAL TREATMENT ORDERS

GOAL A: FOR TREATMENT OF ALL REVERSIBLE ILLNESS

☐ **FOR CPR and appropriate life-sustaining treatments**

→ ***FOR TRANSFER TO HOSPITAL IF** required treatment cannot be provided in the facility*

GOAL B: FOR TREATMENT OF REVERSIBLE ILLNESS WITH FOLLOWING LIMITATIONS

☐ **NOT FOR CPR or INTUBATION - but is for other appropriate life-sustaining treatments**

→ ***FOR TRANSFER TO HOSPITAL IF** required treatment cannot be provided in the facility*

GOAL C: FOR TREATMENT OF REVERSIBLE ILLNESS WITH SIMPLE, NON-BURDENSOME TREATMENT. FOR GOOD SYMPTOM MANAGEMENT. NOT FOR CPR or INTUBATION

☑ **FOR TRIAL OF TREATMENT AT THE FACILITY, if this can be done without causing excessive distress. If deteriorates despite this, for comfort measures only.**

→ ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture***

OR

☐ **NOT FOR LIFE-PROLONGING TREATMENT of new illness / deterioration. All treatment is aimed at comfort and relieving symptoms.**

→ ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture***

→ ***Commence Palliative Care Plan***

GOAL D: COMFORT DURING DYING – TERMINAL CARE (prognosis assessed as hours / days)

☐ **All treatment is aimed at relieving symptoms and supporting the Resident and their family / important others.**

→ ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture***

→ ***Commence Palliative Care Plan***

I have discussed above Goals of Care with ☐ Resident ☑ Medical Treatment Decision Maker *(named above)*

Others involved in discussion RN Lucy

Doctor's name (print): Dr Peter Diac Doctor's Designation: GP

Doctor's Signature [signature] Date: 21/8/20

☐ **Review in _____ months** *OR* ☑ **Review as needed**

CPR = Cardiopulmonary Resuscitation
MEPOA = Medical Enduring Power of Attorney EPOA Personal = Enduring Power of Attorney for Personal Matters
MTDM = the person who is the legal medical treatment decision-maker for the Resident who lacks capacity to do this for themself

GOPC Version Sept 2017

Residential Aged Care Facility **GOALS OF CARE** **Medical Treatment Orders** (For completion by Doctors only)	AFFIX IDENTIFICATION LABEL HERE U.R. NUMBER: _____ SURNAME: Diac GIVEN NAME: John DATE OF BIRTH: 21 / 8 /1920 SEX: M

RACF GOALS OF CARE *is a medical treatment order. It describes a medical treatment plan that takes account of:*
(i) the Resident's medical illness, illness trajectory and the limits to what is medically feasible; and
(ii) the Resident's preferences and values related to medical treatment, within the limits of what is medically feasible.

RECORD OF DISCUSSION ABOUT TREATMENT GOALS AND LIMITS TO TREATMENT ESCALATION

Date / time	*Include details of content of discussion and who was involved*
21/8/20 at 1900	Updated Goals of Care discussion due to Covid risk with MTDM Gaveen Jayarajan: Not for CPR Aim to manage at facility with In-Reach team involvement as needed Explained risk of Covid and potential supportive treatments if patient was to get it eg. steroids (dexamethasone), oxygen, fluids, nutrition and blood thinners (clexane) Also explained that palliative care can be provided in the facility if patient deteriorates acutely Happy to have anticipatory end of life medications added for emergency use if patient becomes terminal Explained highly infectious nature of Covid and that in some situations hospital transfer maybe needed for public health reasons, for example: - if the patient wanders and is unable to be safely isolated - lack of single rooms at the facility - difficulty in maintaining good infection control - shortage of nurses or carers impacting basic care Explained that any hospital transfer is also contingent on hospital capacity, In-Reach team and DHHS decision MTDM understands all of the above  Dr Peter Diac

(date & sign entries; update as needed)

WRITE COMMENTS ON GOAL CATEGORY, IF NEEDED FOR CLARIFICATION OR TO RECORD VARIATIONS
eg. Goal of care is non-burdensome treatment but to receive CPR – tick Box C and write clearly 'FOR CPR'

Ensure a copy of Goals of Care and copies of any Advance Care Planning documents are sent with the Resident if transferring to hospital.

Appendix 13 – RACF COVID-19 Alert Levels Matrix – *DRAFT DOCUMENT - FOR DISCUSSION ONLY*

RACF COVID-19 Alert Levels						
Alert Level	**Definition**	**Visitors**	**Staff**	**Residents**	**PPE**	**Medical Care**
1	No state-wide cases or transmission	• Screening at entry – temperature, presence of symptoms, travel from "hotspot", hand sanitiser, flu vaccination • Encourage use of telephones and video devices as "practice" • Obtain mobile phones for residents capable of using them	• Screening at entry – temperature, presence of symptoms, travel from "hotpot", hand sanitiser • Establish and record where staff reside and other locations they work at	• Obtain and record baseline observations, including oxygen saturation • Alert residents to the possibility of being moved to a different room at short notice • Daily temperature. If any concerns, use COVID-19 screening tool for RACFs. If testing indicated, isolate patient if possible	• Ensure staff are trained in use of PPE, including repeated observed drills for donning and doffing • Ensure donning and doffing stations appropriate set up • Have weekly "PPE" days to increase familiarity (staff, patient and families) with PPE	• Usual GP providing care • Involve GPs in RACF outbreak management planning • Discuss with GPs and local public health services planned roles in the event of an outbreak • Establish resilient communication channels with GPs
2	No regional cases or transmission	• Maximum 2 visitors at any one time • Maintain social distancing; preferably meet outdoors and not in communal areas	• Zone the facility – Zone A, B and C. • Minimise (ideally eliminate) staff cross-over between zones	• Zone the facility – Zone A, B and C. • Minimise (ideally eliminate) patient cross-over between zones	• As above • Any asymptomatic staff from regions with higher transmission to wear a surgical mask	• Conduct GP and public health-led family webinars to discuss outbreak management and ACPs • Practice telehealth
3	Low number of regional cases and/or transmission	• Wear facemasks	• Eliminate staff cross-over between zones	• Eliminate patient cross-over between zones • Daily screening with COVID-19 screening tool for RACFs. If testing indicated, strict isolation.	• All staff to wear a surgical mask	• As above
4	High or substantially increasing regional transmission	• No visitors except on compassionate grounds	• Eliminate staff cross-over between facilities	• As above	• All staff to wear a surgical mask and faceshield	• As above
5	COVID-19 has entered the facility	• No visitors except on compassionate grounds	• Zone the facility – Green Zone (COVID-negative), Amber Zone (COVID-suspected), Red Zone (COVID-positive) • Eliminate staff cross-over between zones • Activate surge workforce plan to replace furloughed staff	• Zone the facility – Green Zone (COVID-negative), Amber Zone (COVID-suspected), Red Zone (COVID-positive) • Eliminate patient cross-over between zones	• All staff with resident contact to wear a N95 mask, faceshield, gown, gloves	• Continue telehealth where possible • For face-to-face care, activate plan for on-site medical staff