COVID-19 and residential aged care: priorities for optimising preparation and management of outbreaks

Recommendations to guide residential aged care facilities in preparing for and managing infectious disease outbreaks

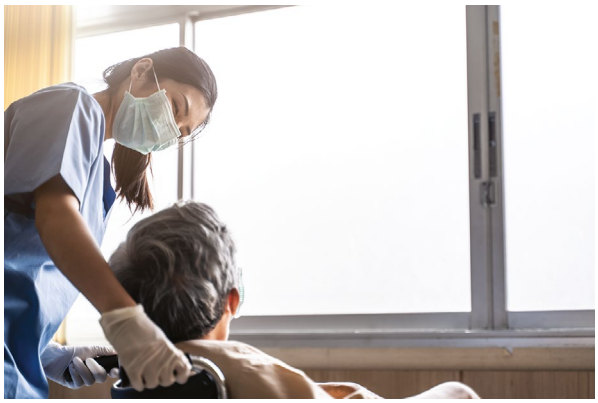
The coronavirus disease 2019 (COVID-19) pandemic is devastating the residential aged care facility (RACF; eg, care homes, nursing homes, long term care) population. Globally, older people living in RACFs comprise almost half (47%) of all deaths from COVID-19,[1] which now exceeds 1.4 million deaths (at 27 November 2020).[2]

Older age and presence of multiple comorbidities are associated with increased risk of severe disease and death from COVID-19.[3] Along with these characteristics, the substantial prevalence of people with dementia and complex care needs further increases the risk of transmission and case fatality rate of COVID-19 in this population. The risk of transmission is amplified by the built environment of RACFs, which are designed to be home-like. Also, the communal style of living, and difficulty in adhering to physical distancing accelerates transmission and spread of infection.

Australia is confronting the situation experienced in many other countries during the first wave of the pandemic. In England, of a total 46 500 deaths due to COVID-19 infection, 19 500 (47%) occurred in RACF residents.[4] Outbreaks affected 6811 of their 15 476 (44%) care homes.[5] Since early June 2020, nearly 30% of RACFs (217/768) in Victoria have reported outbreaks. The number of RACF residents with COVID-19 surged from nine to 1986 people, and RACF residents now comprise 76% (685/907) of all COVID-19-related deaths.[6]

During the initial stages of the pandemic, the Australian Government Department of Health released national guidelines for COVID-19 outbreaks in residential care facilities.[7] The emphasis of the national emergency response to the pandemic was on general public health, acute health services and community dislocations due to the profound economic impacts. Within RACFs, restricting visitors to facilities was the most visible public strategy and was met with considerable debate. The Aged Care Quality and Safety Commission, federal and state governments and public health units are all involved in the pandemic management of aged care; however, it is not clear who was making decisions when outbreaks occurred in RACFs.

Information and empirical evidence about the optimal responses to preventing outbreaks in RACFs were, and remain, scarce. Expert and professional knowledge and skills are important for the development of interventions to improve care in the aged care setting. Clinical practitioners in geriatric medicine or gerontic nursing are experts on the provision of health care in RACFs. Their insights and experiences are important to inform evidence-based prevention, initiatives and policy, especially during this COVID-19 pandemic.



The recommendations we describe in this perspective are informed by a short and rapid consultation with our colleagues in senior aged care medical and nursing professional roles within Victoria, Australia. We focus on identifying the priorities for preparation and the emergency management response to widespread outbreaks. Of the multiple priorities that emerged, three were prominent: outbreak management plans, training of staff, and maintaining an adequate workforce.

Outbreak management plans for sector, organisations and facility

An aged care sector wide management plan should be available with a planning template for aged care providers to complete and submit, and to provide a snapshot of every RACF in Victoria, including a snapshot of existing staffing and supplies. Local RACF management plans should be developed in conjunction with local hospitals, general practitioners, palliative care staff and pharmacies.

Management plans should prepare for any outbreak (COVID-19- or non-COVID-19-related). All staff, including facility staff, GPs and paramedics, should be made aware of the plans and provided with education and guidance regarding their content and implementation. A range of scenarios should be covered within the outbreak management plan.

While recommendations are consistent with advice in the national guidelines,[7] additional areas for inclusion are protocols for managing new and returning

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admission into the RACF, transfer to an acute health service, and management of COVID-19-positive residents in place. Before the pandemic, RACFs in regional New South Wales had varying levels of outbreak prevention and preparedness strategies;[8] however, those with management plans in place reported an increase in outbreak readiness.[9]

Approaches to facilitate comprehensive planning for the unique RACF setting include instigating national taskforces. This has occurred in several countries with varying success.[10] Another approach is integrating agreed standards for outbreak preparation and preparedness into regulatory or accreditation frameworks.

Training of staff

Aged care experts also determined there is an urgent need for additional training for both new and existing RACF staff, training of external health care providers and mental health support.

All staff working within RACFs require upskilling to manage COVID-19-positive residents. This should include education about identification, assessment and management of COVID-19-positive residents, and infection control safety training. In addition, new RACF staff need training before commencement of employment to ensure they have the basic skills and knowledge required to care for residents and support existing staff. Consideration of extending training to external health care providers, such as locum GPs, should be made to create a standardised approach to infection control practices, screening and management of residents with COVID-19.

Some aged care experts suggested that an online mode of training would be most appropriate, including utilising online government COVID-19 infection control training. While online resources are readily accessible, there remains the need to demonstrate learning, rather than simply registering attendance at a training session. Online training provides a feasible method of education for staff as it is not labour intensive and adheres to social distancing requirements. However, empirical evidence of whether learning and practice change occurs is scarce, especially in times of crisis. Lessons learned from a RACF outbreak in Sydney were that additional training by infection prevention and control professionals improved compliance with infection control and contributed to controlling the outbreak.[11] As of early August 2020, the Victorian government is offering free face-to-face infection control for all Victorian RACFs without outbreaks.

Provision of mental health support for staff is more challenging. Counselling should be provided to support the mental health of staff, in order to reduce staff attrition and long term psychological harm. This need is supported by emerging evidence suggesting a considerable proportion of health care workers have experienced mood and sleep disturbances during the pandemic.[12] In the United Kingdom, over 70% of care home managers reported concerns about staff morale and mental health due to the pandemic.[13]

Maintaining an adequate workforce

Maintaining an adequate workforce, including contingency plans, hiring and rostering of staff is vital.

RACFs require contingency plans to account for increased staffing needs to meet the increase in resident care needs and staff attrition, especially in the case of a facility outbreak. RACFs should consider dedicating staff members to COVID-19 outbreak management, including extra nurses to coordinate responses with external providers. RACFs need to identify staff who are willing and able to care for residents with COVID-19, and provide clear communication of new roles and responsibilities that will exist should the facility experience an outbreak.

Sources of staffing may come from a shared register of aged care staff made available to RACFs, who can be called upon as needed. Sources of increasing workforce capability include hiring of existing staff who work less than full-time, students (including health care students), and recently unemployed people from other sectors. RACFs should aim to have continuity of shifts to minimise the number of people entering and exiting the facility over a 24-hour period (eg, create 12-hour shifts).

Pandemic management guidelines advise RACF providers to plan for a 20–30% staff absentee rate.[7] Concerningly, 80% of members surveyed by the Australian Nursing and Midwifery Federation reported no increase in staffing levels in response to the pandemic.[14]

In Australia, the federal government has responded with provision of emergency contingency staff for RACFs, incentives for existing staff (such as retention bonuses), recruitment of health care students and recent graduates, and relaxing pre-existing practice regulations.[10] Despite these initiatives, RACFs still struggled to maintain the staffing levels required during an outbreak.[15] This is consistent with the well documented chronically understaffed and underskilled RACF sector in Australia before the pandemic.[16]

Other initiatives

The three strategies above are only part of the response required. Other important initiatives are described in the Supporting Information and include improving communication with residents and families, the availability of personal protective equipment, and prompt medical and primary health support.

Conclusion

Consideration of these recommendations by government and other key stakeholders will assist RACF staff and providers to better prepare for infectious disease outbreaks and maintain standards of care.

The COVID-19 pandemic is a unique situation whereby the normal time frame from formulation to implementation of recommendations must be reduced. While all levels of government have provided guidance to RACFs during the pandemic, there has not been a centralised specifically

dedicated and functional body with geriatric and gerontic expertise leading the aged care response and providing information to RACFs. The absence of such a body will hamper actioning any recommendations. Our recommendations highlight some key areas not fully addressed in the current response and, if implemented, could have a positive impact in optimising RACF responses to infectious disease outbreaks.

Note: A detailed report of these recommendations was compiled and distributed (May 2020) to relevant government authorities and organisations involved in the management of the pandemic and RACFs. Please contact the authors for a copy.

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Supporting Information

Additional Supporting Information is included with the online version of this article.

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