Aged Care Association
NEW ZEALAND

Aged Care Association submission to the Royal Commission of Inquiry into Covid-19 Lessons Learned

October 2023

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About the Aged Care Association

This submission is from the Aged Care Association (ACA), the peak body for the aged residential care (ARC) sector in New Zealand.

New Zealand has over 670 aged residential care facilities, with more than 40,000 beds and 35,000 residents. In comparison, Te Whatu Ora oversees 10,748 public hospital beds.

Our members provide rest home, hospital, dementia, psychogeriatric, respite, and palliative care and care for around 700 younger people with disabilities.

Sixty six percent of beds are run by religious institutions, charitable trusts, family-owned, not-for-profits, and privately owned facilities. Most of the remaining beds are operated by listed companies (34 percent), with less than 1 percent provided by Te Whatu Ora.

Residents may be

- very frail and clinically unstable,
- well but disabled and have very high care needs,
- cognitively impaired or with mental health issues, with some requiring a secure environment,
- receiving end of life care.

Funding for aged residential care is a mix of means-tested user-pays and government subsidy.

Aged residential care providers are contracted by Te Whatu Ora (DHBs at the time of the Covid-19 pandemic) to provide care services at a rate that is set annually.

The aged care workforce is under-resourced and overworked.

The ACA's Nursing Leadership Group (NLG) welcomes the opportunity to make a submission to the *Royal Commission of Inquiry into Covid-19 Lessons Learned*. The Association is available for discussion at any time that suits the Commission.

Background

Covid-19 in the aged care sector

The Covid-19 pandemic has been the greatest challenge the aged care sector has faced.

Residents, their families, and aged care staff all suffered. The suffering has not been confined to those homes which experienced outbreaks. Thousands of residents in homes that have not had outbreaks have endured long periods of Covid-19 settings and measures that resulted in isolation from their support networks, fellow residents, and relationships with staff. Some residents moved into care and died without seeing the faces of the staff caring for them. While not proven, this is likely to continue to impact on physical, mental, and emotional wellbeing.

The first positive case of Covid-19 in a rest home was on 22 March 2020, just three weeks after the first confirmed case in Aotearoa New Zealand. The aged care sector was on high alert due to the impact of Covid-19 on older adults being reported internationally and witnessing, via media, the traumatic deaths of older people without any support during this process.

This was a fearful time for residents, staff and families/whānau.

The Aged Care Association and its nursing leadership group spent a lot of time helping DHB managers understand the practice setting of aged residential care, and the skills of the staff who were delivering care - many of whom had successfully managed outbreaks in facilities before.

Aged residential care facilities are not small wards or hospitals; they are large residential homes where people live – not clinical environments.

The perception of aged residential care

Aged residential care is not held in the same esteem as other areas of healthcare.

During the Covid-19 response this manifested as a lack of understanding of the needs of the sector. DHBs, the Ministry of Health and government representatives often made decisions without appropriate representation from ARC, resulting in decisions that were impractical and inappropriate. Different regions had different expectations for the ARC sector.

At the request of the Director General of Health, DHBs were undertaking audits to ascertain ARC preparedness for the Covid-19 response. The Ombudsman also initiated unannounced inspections of dementia facilities.

Media were reporting on outbreaks in ARC, giving the impression that any resident testing positive for Covid-19 was an ARC sector failure. The media desire to name and blame made the aged residential care sector daily news. This was later remedied to a small extent by documentaries that provided a more balanced view of the resident and staff experience during this time.

Within the ARC sector there was never a blame mentality in relation to outbreaks, simply a desire to support and learn more from each other about how to manage the immediate risk.

The use of personal protective equipment (PPE) was always on the agenda; what to use when; whether it was appropriate for residents to wear masks; how and where to don and doff. Solutions needed to be applied to a variety of different ARC building environments, ranging from small to large, modern to old.

Recommendations

1. The Aged Care Association should be the National Aged Care Advisory Body to government.
2. ARC nurse leaders and NLG to be pivotal in discussions and decision-making impacting ARC from the outset.
3. Identify ARC leaders in the National Pandemic Plan so all key stakeholders are known and part of the planning - pre, during and post event, regardless of whether it is a pandemic, severe weather event, earthquake or other emergency.
4. The ARC sector to be kept up to date via one source of accurate, verified key information as the situation evolves.
5. Enable equitable access to PPE for all healthcare providers.
6. Provide access to IPC experts and support providers to apply the principles within their specific ARC context.
7. Visits must be humane and proportionate to risk. PPE and safety protocols can be applied to close family to enable a resident to have a dignified death.
8. Decisions about residents in ARC should remain with the provider. Management teams must be able to maintain control unless there is clear evidence they are not acting in the best interests of the residents.
9. The ARC facility is the resident's home and must remain so during a pandemic.
10. Future management of a pandemic or any national event needs to ensure an equity lens is applied to the settings, resources, equipment and support to drive the best outcomes for older people of Aotearoa.
11. Providers need funding support that is flexible and nimble to manage additional workload and tasks.
12. The sector's networking strengths need to be driven from a central body that is accessible and responsive for all, such as the Aged Care Association.
13. Workforce planning is difficult, but vital to any emergency response.
14. Work towards a technology literate workforce.
15. Ensure equitable access of technology solutions across the sector.
16. Make sure ARC funding supports remote and alternative ways of working that meets the care needs of residents.
17. Work closely with ARC clinical leaders / NLG to understand the skill set in the sector and how it can relieve some burden from the wider sector.
18. Think about 'how' instead of 'why not'.
19. Keep resident outcomes and practical solutions front and centre.

1. Collaboration and communication

Collaboration and effective communications were not a feature of the early weeks of the pandemic.

Advice and guidelines being sent to, from and between various parts of the health and disability sector were fragmented and lacked structure, and the ARC sector grappled with the copious amounts of information. Information and expectations were coming from: overseas experience, the media, government announcements, the Ministry of Health, individual district health boards, public health authorities, our peers, and more.

All the while ARC nursing leaders were working to

- make sense of the information, update and condense it into responsive, practical pandemic plans,
- re- shape information to make sure it was fit for purpose for smaller ARC providers who did not have the infrastructure to create documents and forms as examples, as well as
- relay information to residents, staff and whānau who were seeking guidance and reassurance, and
- respond to requests for information from our Boards, DHBs, local councils and other agencies.

Aspects of our pandemic plans were not able to be executed due to Government directives to suppliers to centralise all the supply chains.

Initially the focus of the pandemic response was strongly geared towards the acute sector, which caused significant frustration and barriers to appropriate care in ARC.

These decisions were out of alignment with the known risk to frail older people of contracting Covid-19

1. a. For example

Different DHBs had different requirements including different protocols for hospital admissions and discharges. This made it challenging for large operators to have consistent documentation across their facilities.

The sector had to push hard to be involved at the right level to influence decisions and ensure care for residents and business continuity.

There was no real connection between the ARC sector and the national Technical Advisory Group (TAG) despite requests and offers to have an aged care expert attend to help explain how the theoretical information could be applied effectively in a practical sense in ARC.

1.b. What we did

The ACA nursing leadership group used all their professional networks and connections across the sector to gain visibility.

DHBs were concerned about bed availability and hospital outbreaks and were advocating for ARC to take Covid-19 positive residents. Transferring Covid-19 positive residents during this phase would have resulted in more ARC outbreaks, significant workforce shortages and increased deaths related to Covid-19.

NLG co-designed screening tools for hospital-to-ARC transfers. This prevented infectious, Covid-19 positive patients being transferred into ARC facilities.

After significant lobbying, NLG representatives were able to participate in regular meetings with the Ministry of Health. Being able to provide input into the shaping of the response guidance and key documents relevant to the ARC sector was pivotal, and improved support for the sector. As a result, guidance was relevant when it was published and could be quickly implemented by providers. Enhanced communication and mutual respect developed, improving outcomes for residents, staff and whānau.

The sector adapted quickly and brought significant innovative ideas forward. These included virtual health professionals and whānau visits.

1. c. What we learned

Making sure the ARC sector voice is recognised and can represent the perspectives of aged care stakeholders is very important to achieving better outcomes. Residents, whānau, nurses, caregivers/activities staff, kitchen/laundry/housekeeping staff, medical and allied health, pharmacy, managers, owners, Board members, suppliers can have a voice through the Aged Care Association.

ARC could have provided more support to the wider health sector if it had been recognised as a key part of the system earlier.

1. d. In future

The Aged Care Association should be the National Aged Care Advisory Body to government.

ARC nurse leaders and NLG to be pivotal in discussions and decision-making impacting ARC from the outset.

Identify ARC leaders in the National Pandemic Plan so all key stakeholders are known and part of the planning - pre, during and post event, regardless of whether it is a pandemic, severe weather event, earthquake or other state of emergency.

The ARC sector to be kept up to date via one source of accurate, verified key information as the situation evolves.

2. Personal protective equipment

In a unilateral decision, the government requisitioned all available personal protective equipment (PPE), which meant that the companies that usually supplied ARC facilities were no longer allowed to. Aged care facilities struggled to source the PPE required to prevent and manage outbreaks.

Requests to government agencies for supplies were met with the condescending response that the sector should do what it usually does if it needs PPE. The sector's ability to act autonomously and in the best interests of its residents was removed.

Centralised control and decision-making in an environment where aged residential care was not prioritised (if it was considered at all) put tens of thousands of elderly New Zealanders at greater risk of infection than was necessary.

International literature confirmed the virulence and airborne nature of the virus, and it became clear we needed N95 masks. We pushed for N95 masks but were not issued these initially. When they were, we did not have the resources to effectively fit test ARC staff.

We are experts in aged care and wanted to apply evidence-based practice to our setting. This was significantly hampered and created unnecessary tension. DHBS and the Ministry of Health needed to be disabused of the notion the need for PPE in ARC was less important than in hospital settings.

There was a long delay in providing funding so smaller ARC providers could access PPE. These delays resulted in inequities - larger providers were able to secure supplies but smaller providers did not get the support they needed in a timely manner. Of note however, many large providers provided smaller providers with PPE in the early stages of the pandemic until supplies from the Ministry of Health were able to be distributed.

2. a. For example

One major supplier to the sector, EBOS, was required to give control of its stock over to central government, leaving ARC with no choice but to try and find new suppliers. Accessing stock was difficult, time consuming and expensive. Small providers had no capacity to purchase at the exorbitant prices from overseas suppliers.

Our usual infection prevention and control (IPC) plans were unable to be implemented as we could not access our usual business-as-usual PPE, let alone the quantities required to ensure pre-emptive IPC precautions.

When we were eventually able to requisition stock from the central supply, we were supplied with vinyl gloves; nitrile gloves were only available for the 'front line'. ARC staff were having to use vinyl, food grade gloves for incontinence rounds and general body fluid contact. These gloves are not cuffed or sealed and were exposing staff to unacceptable risks.

When the rest of the health system was using N95 masks, the ARC sector was provided with standard medical masks.

Much of the stock provided from the central stores was so far past their expiry dates that we heard of staff opening boxes of supplies to find the contents had completely disintegrated.

The best practice of having N95s fit tested was not available in an equitable manner across the sector, which created risk to older people and staff.

2. b. What we did

We relied on a lot of our industry contacts, contacted local MPs, asked for written confirmation that the sector would be supported if any staff suffered consequences of being exposed to infection due to inadequate PPE.

By raising the profile of ARC and promoting the sector as part of the health system we were eventually given access to PPE via the central portal.

2. c. What we learned

There must be clear guidance for distributing PPE equitably. If PPE is required for acute staff, it is required by ARC staff.

2. d. In future

Enable equitable access to PPE for all healthcare providers.

3. Infection prevention and control

ARC providers were treated as though they did not understand IPC principles. A lot of "this is how you must do it" came from the DHBs, but different doesn't mean wrong. The ARC sector is very capable of applying IPC principles appropriate to the ARC context. Buildings and ventilation systems were never designed to prevent airborne infections from spreading but this is what DHB managers expected.

Covid-19 PCR saliva testing was undertaken in some facilities as a precaution. However, this was not funded by the Ministry of Health.

There were instances of older people being denied access to public hospitals, in case they "bought in" Covid-19. Aged care residents were triaged in car parks: one was a cardiac event – the resident was sent back to the rest home. Medical care was not provided, and the resident was treated with a lack of respect, comfort and reassurance.

3. a. For example

DHBs started auditing ARC facilities during the pandemic. DHB representatives, some who had never worked in ARC, were sent to audit providers during a time when providers were ramping up their pandemic response, often in the context of workforce shortages. The audits took away valuable time and resources from the response and felt like a 'big brother' approach and disrespectful of sector knowledge rather than being supportive.

Often the recommendations were impractical and not appropriate for the ARC sector, for example, cohorting positive cases by moving residents to different rooms or expecting residents in dementia units to adhere to isolating in their rooms.

3. b. What we did

While some advice and support was well received, the sector also spent considerable time educating IPC and DHB staff about why hospital based IPC interventions were not always appropriate in ARC and in some instances would create more risk.

3. c. What we learned

Before the next pandemic, whatever that is, the sector needs to do the work to make sure there is a better understanding of the expertise, systems and processes in ARC and that doing it differently does not mean doing it wrong. IPC principles may be applied differently in different contexts.

3. d. In future

Provide access to IPC experts and support providers to apply the principles within their specific ARC context.

4. Decision-making and compassion

In some cases, facilities were taken over by a DHB, to the detriment of residents and whānau. The expertise of ARC providers and staff was dismissed, and decisions were made that were not in the best interests of residents their whānau.

The restriction of visits between residents and their friends and families has had tragic, irreparable, and lasting effects. The benefits of such visits cannot be wholly replaced with technology.

Many residents experienced restrictions that went beyond those endured by the general community. Some facilities saw an increase in depression, anxiety and confusion in residents.

The impact of grief and death on staff and families was significant and not sufficiently acknowledged.

There were times when Government rules were not applied consistently across the sector, resulting in poor outcomes, such as families not being able to view their deceased loved ones.

4. a. For example

When an outbreak first occurred in ARC the provider was made out to be a villain, with media on their doorstep and the decision-making taken away from the provider.

ARC facility staff were sidelined, with people unfamiliar with the residents and their whānau doing the communications. This created stress for residents, whānau and staff.

Frail, cognitively impaired residents were taken away from their homes to public hospitals increasing the risk of delirium and adverse outcomes of care.

I believe that one of the greatest tragedies in this pandemic was
not being allowed to be with my mother when she died.
The companionship of family members is very comforting to both.
Not being able to visit generated anguish and uncertainty;
I never got to see her and say goodbye.
Bereaved daughter, 59 years

Some facilities acknowledged the success of keeping the virus out, but at what cost?

4. b. What we did

The situation was reviewed, and this did not become commonplace in future management of Covid-19 outbreaks even where there were staff shortages.

A number of initiatives by providers included

a) Some providers did enable compassionate visiting earlier where they were able to be more flexible. Close family/whānau were eventually able to visit at all facilities on compassionate grounds even during lockdowns and outbreaks.
b) A concierge service to coordinate and screen visitors (had to divert staff to do this).
c) dedicated communications team to facilitate communication between families and residents.
d) Infection control and PPE training for families to ensure safe visits.
e) The *No One Dies Alone* programme was implemented.

4. c. What we learned

The mental health and spiritual needs of both staff and residents are important and must be considered.

4. d. In future

Visits must be humane and proportionate to risk. PPE and safety protocols can be applied to close family to enable a resident to have a dignified death.

Decisions about residents in ARC should remain with the provider. Management teams must be able to maintain control unless there is clear evidence they are not acting in the best interests of the residents.

The ARC facility is the resident's home and must remain so during a pandemic.

5. Staff resilience and stress

ARC staff reported emotional and physical exhaustion, including feelings of helplessness, moral distress, isolation, burnout and symptoms of post-traumatic stress disorder. Some also reported feeling humiliation and personal failure because of community criticism, negative media coverage and the inability to meet fast-changing requirements, despite their best efforts.

Staff worked extraordinary hours, beyond the call of duty often at significant personal cost. Employers did not want staff to overwork but were faced with very difficult choices. Residents need to be cared for no matter how many workers are sick themselves, and the supply of overseas workers was shut off due to border closures.

It became very difficult to ensure staff did not become burnt out/exhausted. Once a facility is at a critical staffing level not much more can be done.

Staff typically went beyond the call of duty out of the kindness of their hearts as they recognised there were no other options to maintain resident care services. Managers and support office staff pitched in and did shifts and jobs they wouldn't usually do.

Covid settings created additional workload for staff; in particular, the processing of visitors during different stages of the pandemic and managing resident and whānau/family expectations and frustrations. Many providers were able to employ students during term breaks but this was not easily achieved for all providers.

A national workforce agency was established but it provided little support to ARC as the healthcare workers generally had no or little aged care experience and were not able to easily adapt to the ARC setting.

Government settings for different sectors, such as education, were sometimes unhelpful, with staff contracting Covid-19 and having to isolate. This worsened staff shortages.

Staff who were vulnerable to the effects of Covid-19, including pregnant people, were fearful of being exposed.

5. a. For example

Staff worked short-staffed when their colleagues were isolating or looking after sick family members. Staff worked longer and more days in a row to maintain services. This went on for months.

Some national workforce agency staff worked during outbreaks but generally they were not used to leading caregiver teams, and did not meet expectations. There was insufficient time and resource during the crisis to provide robust orientation.

5. b. What we did

Adopted twice daily standup meetings - involving representation from all areas of the facility.

Adopted a sector wide “hub-and-spoke” knowledge sharing approach.

Staff Covid-19 testing prior to shifts assisted with avoiding outbreaks. Eventually borders opened, and immigration settings changed to prioritise healthcare workers. Some DHBs identified staff who had prior experience in ARC and made them available to support ARC facilities.

5. c. What we learned

The importance of peer collaboration and connection, and the promotion of resilience and well-being.

Discussions with peers were an important source of emotional and moral support to healthcare workers struggling with so much uncertainty and responsibility.

It is very difficult to prepare for the staffing shortages that occur in a crisis. Maybe specialised crews could be established, resourced and available to go in and help if required at short notice anywhere across Aotearoa. Despite the challenges, teams pulled together and were proud of how they maintained services during unprecedented times.

The pandemic created new vulnerabilities in ARC, for example: staff shortages, and exacerbated existing vulnerabilities.

5. d. In future

Future management of a pandemic or any national event needs to ensure an equity lens is applied to the settings, resources, equipment and support to drive the best outcomes for older people of Aotearoa.

Providers need funding support that is flexible and nimble to manage additional workload and tasks.

The sector’s networking strengths need to be driven from a central body that is accessible and responsive for all, such as the Aged Care Association.

Workforce planning is difficult, but vital to any emergency response.

6. Innovation and technology

The sector adapted quickly using technology and innovative ideas to respond to the evolving situation. Technology became essential as we worked together across the country to solve common problems.

Together, the sector learned to reconfigure spaces for visitors, build drive-through tents, and develop checklists and protocols.

We developed new approaches to maintain social connection for residents and whānau, and disseminate information to ARC providers and families. A common theme was a strong focus on providing staff and residents with choice and control.

6. a. For example

Use of Zoom / Teams for GP rounds, physio assessments, specialist reviews, contact with families/whānau, pastoral care, church services and other community events.

The NLG collaborated, meeting daily via Zoom to share learning and information and plan actions which were made available to ACA members.

6. b. What we did

The sector was very good at finding solutions to multiple challenges.

6. c. What we learned

The sector was very committed and agile with a strong culture of collaboration.

Initiatives established during the pandemic should be documented for use in future, or maintained if they are applicable in non-pandemic times. Maintenance of some innovations may require additional funding.

Some of the innovations that were developed during the pandemic can inform best practice for ARC.

6. d. In future

Work towards a technology literate workforce.

Ensure equitable access of technology solutions across the sector.

Make sure ARC funding supports remote and alternative ways of working that meets the care needs of residents.

7. Utilising ARC expertise

Many ARC providers tried to take the stress off other very stretched parts of the health system by offering to take their own blood tests, PCR swabs and provide vaccinations to staff, residents, and others.

Unfortunately, again, many DHBs had a singular focus on maintaining control of all pandemic services and would not allow ARC experts to relieve some of the pressure they were under.

There were different responses from different DHBs.

7. a. For example

In one DHB the laboratory staff provided online training for RNs who had previously done phlebotomy in other roles or countries, supplies were dropped off and aged care providers called the lab when

they had collections. This meant lab staff didn't have to waste time donning and doffing PPE, exposing residents to another staff member, and ARC staff could obtain samples in a timely fashion.

Lab staff and the DHB worked with the sector and sent step by step instructions for ARC staff to do PCR testing. We were then able to manage our own screening and testing taking the pressure off the DHB staff who were needing to test the public.

We had a lot of lead in time to get staff on site upskilled to be able to vaccinate when the Covid-19 vaccinations arrived. This process became unnecessarily complicated and the sites that did get people certificated then had their staff head-hunted by the DHBs to become vaccinators at a much higher rate than ARC could pay.

Often our pharmacies or GP practices manage the vaccination of our staff and residents for the annual flu vaccinations, but with Covid-19 we were not able to use our normal systems because the DHBs held all the vaccinations and were requiring hours of time from us to inform them of our numbers, consent processes etc.

7. b. What we did

Staff in the aged care sector spent many hours working with contacts in the DHB, fighting to be able to care for our own staff and residents.

We remained risk and resident focussed and shared examples of what worked well.

7. c. What we learned

With support and adequate workforce ARC can take a lot of pressure off the acute health sector.

7. d. In future

Work closely with ARC clinical leaders / NLG to understand the skill set in the sector and how it can relieve some burden from the wider sector.

Think about 'how' instead of 'why not'.

Keep resident outcomes and practical solutions front and centre.