

**Newmarch House
COVID-19 Outbreak
*[April-June 2020]***

Independent Review

Final Report

Conducted by:

Professor Lyn Gilbert AO
Adjunct Professor Alan Lilly

20 August 2020

Acknowledgements

The reviewers would like to acknowledge all of the people who participated in the Independent Review of Newmarch House and thank them for their respective contributions. We would also like to acknowledge and thank the secretariat staff who helped manage logistics throughout the course of the review.

At the time of the COVID-19 outbreak at Newmarch House, no other residential aged care home in Australia had experienced an outbreak of such magnitude.

The outbreak has had an enormous impact on the residents, their families, the staff of Newmarch House and the broader Anglicare community. Sadly, 19 residents died. To all those families and friends who lost their loved ones during the outbreak, we extend our sincere condolences at this sad time.

These quotes from people we interviewed, encapsulate the challenge and the context in which Newmarch House was operating:

“I couldn’t believe this was happening in my country”

[Staff Member, Aspen Medical]

“... although we were preparing; I thought we were prepared. Nothing prepared us for what was to come.”

[Medical Specialist, Nepean Hospital]

“So to be honest with you and I feel terrible to say it but nothing worked well from the outbreak ... that's not to say, I have absolute gratitude for all of those workers who had the courage to turn up when they did.”

[Family Member, Newmarch House]

Contents

	Page
Executive Overview	4
Introduction	6
The Review	6
Limitations	
Scope	
Context	8
Emergency Response	10
Outbreak preparedness	
Role of Government and Regulatory Agencies	
Regulatory Interventions and Anglicare Response	
Leadership and Management	13
Communications	14
Staffing	16
Medical and Clinical care	19
Rationale	
Implementation of Hospital-in-the-Home and Virtual Aged Care Service	
Role of General Practitioners	
Clinical Care	
Infection Prevention and Control (IPAC)	22
Background	
Anglicare COVID-19 IPAC preparedness	
IPAC during the COVID-19 outbreak at Newmarch House.	
Personal Protective Equipment	
NSW Clinical Excellence Commission IPAC Review	
Response to the Clinical Excellence Commission’s IPAC Review	
Family Experiences	26
Conclusions	30
Appendix I	32
Summary of Key Learnings	
Appendix II	34
Reviewer Professional Profiles	
Appendix III	35
Summary of Review Meetings & Written Feedback	

Executive Overview

This Independent Review was commissioned by the Commonwealth Department of Health (the Department) to learn from the COVID-19 outbreak at Newmarch House in western Sydney, New South Wales. Newmarch House is owned and operated by Anglicare Community Services (Anglicare) and is currently accredited by the Aged Care Quality and Safety Commission until December 2021.

The outbreak commenced on 11 April 2020 and was declared over on 15 June 2020. During this period, 71 cases of COVID-19 were diagnosed in residents and staff members.

In commissioning the review, the Department was keen to understand what had occurred and what could be learned from the experience at Newmarch House. The review was undertaken by Professor Lyn Gilbert and Adjunct Professor Alan Lilly.

The reviewers conducted meetings with government agencies and other service providers involved in the oversight or management of the outbreak. They also met with family members and advocacy organisations, as well as receiving written feedback from families.

The COVID-19 outbreak at Newmarch House was the largest of its kind at that time in Australia and occurred when preparation planning was in its early phase. Australia was on a steep learning curve and looking to international experiences and comparisons to understand what lessons could and should be adopted locally.

In keeping with the scope of the Terms of Reference, the reviewers explored a number of key areas and found that:

Emergency response and interagency operations were characterised by a lack of clarity in the relationships and hierarchy among government health agencies, including Nepean Blue Mountains Local Health District, NSW Health, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission. This created confusion for Anglicare Board and managers, who were unfamiliar with the state agencies and the hierarchy of decision-making in the context of a COVID-19 outbreak;

Leadership and management at Newmarch House and in the broader Anglicare organisation, was generally invisible to external parties interacting with them. Whilst their efforts were recognised by many, the shortcomings in leadership raised concerns for the Aged Care Quality and Safety Commission (the Commission) which has regulatory oversight of Anglicare as the Approved Provider. During the course of the outbreak, the Commission delivered a series of regulatory interventions, the culmination of which led to the requirement to appoint an independent Adviser. Following these interventions, leadership was stabilised with external support;

Communication was consistently highlighted as an issue for families who felt disconnected from their loved ones during the course of the outbreak. Not only did this have an adverse impact on them, it also increased the isolation of their loved ones, the residents at Newmarch House. Making regular contact with family members in a meaningful way presented numerous challenges and tested system capacity to its limits. Challenges with communication also extended to advocacy and other support agencies trying to ease the situation at Newmarch House;

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. In some cases, loss of staff to quarantine was exacerbated due to poor quality or incorrect use of personal protective equipment (PPE);

Infection Prevention and Control (IPAC) was identified as a significant concern with shortcomings identified in the early, crucial phases. Routine IPAC practices needed to be significantly upgraded to meet the challenge of containing the spread of COVID-19. This required the expertise of an experienced IPAC professional. IPAC was further challenged in an environment built and furnished as the residents' home;

Medical and clinical care was led and delivered primarily by the Hospital-in-the-Home (HITH) program in consultation with the Virtual Aged Care Service (VACS) at Nepean Hospital, GPs, locum medical staff and nursing staff at Newmarch House. Whilst HITH has many advantages for elderly residents and the health system, its implementation was compromised by inadequate staffing and support. Many residents and their families felt that it often failed to fulfil its promise to provide care equivalent to that of inpatient hospital care;

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.

The following report discusses each of these areas in more detail and incorporates *key learnings* to inform future practice. A summary of the *key learnings* is attached at Appendix I.

Introduction

Newmarch House is located in the western Sydney residential suburb of Kingswood, New South Wales, approximately 50km from central Sydney. It is a residential aged care home registered for 102 aged care places. It is owned and operated by Anglican Community Services (Anglicare) as the registered Approved Provider under the Aged Care Act 1997 and is one of more than 20 residential aged care homes operated by Anglicare across Greater Sydney.

Approved Providers have specific responsibilities under the Aged Care Act 1997 with regard to: (i) the quality of care they provide (ii) the user rights of people receiving care and (iii) being accountable for the care provided.

Anglicare is overseen by a Board of Directors established under the Anglican Community Services Constitution Ordinance 1961 (the constitution). The Board currently has 10 members and is chaired by Greg Hammond OAM. Under the constitution, the Board appoints the Chief Executive Officer (CEO). The current incumbent in this role is Grant Millard who has been in post since September 2016.

Newmarch House was opened in 2012 and since that time, it has enjoyed an exemplary accreditation history. Following a commencing accreditation in December 2011, it was fully accredited by the (then) Aged Care Standards and Accreditation Agency in November 2012 and subsequently in November 2015 and November 2018, in keeping with the triennial accreditation cycle. On each occasion, Newmarch House met 44 of the 44 *expected outcomes* across the four required standards: (i) management systems, staffing and organisation development; (ii) health and personal care; (iii) resident lifestyle and (iv) physical environment and safe systems. Its current accreditation period expires 30 December 2021. As such, Newmarch House is yet to be fully assessed under the Aged Care Quality Standards which came into effect on 1 July 2019. The implementation of the Aged Care Quality Standards is monitored by the Aged Care Quality and Safety Commission which was established in 2019.

The Review

The Independent Review was commissioned by the Department of Health and formally commenced on 29 June 2020. It was conducted over a period of six weeks by Professor Lyn Gilbert and Adjunct Professor Alan Lilly. The reviewers have specific experience and expertise in infectious diseases, infection prevention and control and residential care. Their professional profiles are outlined in Appendix II.

During the course of the review, the reviewers met with a number of key staff from Anglicare Head Office and Newmarch House, the Aged Care Quality and Safety

Commission (the Commission), the Department of Health (DoH), NSW Health (Public Health Emergency Operations Centre); the NSW Clinical Excellence Commission; the Nepean Blue Mountains Local Health District (Nepean Hospital and Public Health Unit), SA Health and Aspen Medical. Importantly, the reviewers also met with family members of current and recently deceased Newmarch House residents and representative of the Older Persons Action Network and Senior Rights Service (NSW) - advocacy bodies which supported residents and family members during the outbreak. Finally, the reviewers met with some general practitioners caring for residents in the home.

More than fifty hours of individual and group meetings were conducted during the course of the review, involving conversations with more than sixty individuals and the review of written submissions from family members of residents. A summary of meetings and submissions is attached at Appendix III. For the purpose of the review, the reviewers also received many policy documents and communication materials from Anglicare and other agencies involved in the management of the COVID-19 outbreak. The review was supported by a small secretariat from the Commonwealth Department of Health.

Limitations

During the independent review period, Newmarch House was still operating under the requirements of a *Notice to Agree* issued by the Commission on 6 May, 2020 and was visited by the Commission assessors for an unannounced Assessment Contact review in early July. Additionally, Anglicare had commissioned and commenced its own external review. Collectively, these provided a significant administrative burden on Anglicare management, which was still regrouping after the outbreak. In turn, this delayed the reviewers' planned site visit to Newmarch House, interviews with Anglicare staff and Board Directors as well as the receipt, collation and review of relevant documents. A brief site visit was undertaken by a single reviewer on 28 July 2020, as border restrictions prevented the second reviewer attending. As a result, there were no direct interviews with residents but the resident perspective was considered in interviews with family members.

Scope

The Terms of Reference outlined the scope of the review, which included:

- preparedness of the aged care facility for a COVID-19 outbreak;
- infection prevention and control processes within the home;
- leadership and governance during the outbreak;
- the outbreak experience for Newmarch residents and families;
- the support arrangements with the state and federal agencies;

as well as the identification of lessons to be learned from the outbreak.

Consideration of the following factors were specified as not included in Terms of Reference, except as they arose incidentally during the course of the review:

- personal health details of residents and staff;
- contact tracing;
- financial implications of the outbreak;
- regulatory action of the Aged Care Quality and Safety Commission.

Context

The COVID-19 outbreak at Newmarch House commenced late on 11 April 2020, following confirmation by the Public Health Unit that a staff member had tested positive for COVID-19. It went on to become what was, until recently, the most significant outbreak in a residential aged care facility in Australia.

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. At the end of the outbreak, 37 residents and 34 staff members had tested positive for SARS-CoV-2, the virus that causes COVID-19, and 19 residents had died. 17 of these deaths were directly attributed to COVID-19, a mortality rate of 46% of the COVID-19 positive residents at Newmarch House.

The residents were mothers, fathers, grandparents, aunts, uncles and friends. The outbreak created much angst and concern for them and their families and considerable anger towards Newmarch House staff, in the broader community. Communication with Anglicare and Newmarch House staff failed to meet the needs of family members and clearly, this exacerbated the existing crisis. The congregation of media outside the home also exacerbated concerns of many relatives and staff members and made an already depleted workforce fearful of coming to work.

Communication was also challenging between and within the various agencies involved in management of the outbreak. It was reported by many informants that it was often unclear who was in charge at Newmarch House. There were frequent competing demands from external agencies for information and updates on the outbreak and residents' status, which created further stress for on-site managers

and frontline staff attempting to manage an unprecedented crisis. Many stakeholders interviewed for this review, commented that during the first three weeks of the outbreak, the situation within Newmarch House was disorganised and chaotic. 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. This was especially apparent in the first few days of the outbreak, as the number of new cases accelerated. Growing from one case on day 1 to 15 on day 5 and 52 by day 15, the outbreak unfolded rapidly, with enormous impact on residents, their families and staff.

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.

In the context of an accelerating and complex pandemic emergency, Anglicare also quickly enacted its own emergency plan and established a Crisis Management Team (CMT) which provided leadership, oversight and integration of the broader Anglicare outbreak preparedness planning. CMT meetings commenced on 12 April 2020 and at the peak of the outbreak were being held seven days per week. They were ongoing at the time of the review.

Responding to initial and ongoing concerns about the outbreak at Newmarch House, the Commission delivered a series of Notices and remedial actions under the provisions of the Aged Care Quality and Safety Commission Act 2018. These included an administrative direction on 23 April 2020, a Non-compliance Notice on 3 May 2020 and finally, a Notice to Agree on 6 May 2020. The second Notice outlined a number of requirements, including suspension of the admission of new residents and the appointment of an Adviser.

The COVID-19 outbreak was formally declared over on Monday 15 June 2020, some 65 days after it commenced on 11 April 2020.

Emergency response

Outbreak preparedness

By early March 2020, the Anglicare board and executive were aware of the possibility that a COVID-19 outbreak could occur with potentially serious effects on the elderly residents of their homes. Outbreak preparedness plans were underway and were also discussed and developed at several special Board meetings during

March 2020. These plans included: additional staff training in IPAC; review or development of relevant policies and procedures, based on national and state guidelines and their implementation in individual homes; supplementation of existing supplies of (PPE) and importantly, establishment of a surge workforce. They had discussions with managers at BaptistCare about their experience with the ongoing (at the time) outbreak at Dorothy Henderson Lodge. Anglicare facilities, including Newmarch House, were closed to visitors on 23 March 2020. However, when the first COVID-19 case was diagnosed at Newmarch House on 11 April 2020, no one anticipated the magnitude of the challenge that would emerge.

The planned surge workforce of 50 staff was based on a conservative estimate of 30-40% attrition of permanent staff because of isolation or quarantine. This was in excess of official advice to plan for 20-30% staff attrition. By early April, 30 of the planned 50 volunteer personal carers and nurses had been recruited and received additional training and were ready to be deployed. The additional training consisted of a half-day course, which included but was not limited to IPAC.

Daily meetings of the Anglicare CMT began immediately, to monitor the rapidly evolving situation. The response to the escalating crisis was hindered by previously recognised weaknesses in the Newmarch House team management, which, according to several informants, were rapidly exacerbated by the demands of the outbreak.

Key Learning: problems with management need to be addressed as soon as possible after they are recognised.

Role of Government Health and Regulatory Agencies

On 12 April 2020, public health officers from the Nepean Blue Mountains Public Health Unit (PHU) identified seven staff members who were close contacts of one or both of the first two cases (one staff member and one resident) and required them to home-quarantine. Professor James Branley, Director of Infectious Diseases at Nepean Hospital, visited Newmarch House the same day and recommended that residents with COVID-19 be admitted to the Nepean Hospital hospital-in-the-home (HITH) program, in accordance with established Nepean Blue Mountains Local Health District policy for COVID-19 patients. The policy was based on the well-established benefits of HITH, for patients and the health system, the fact that the majority of COVID-19 patients had mild symptoms and the perceived risk of transmission to inpatients and staff, from COVID-19 positive inpatients. HITH had been successfully implemented by Nepean Hospital for many COVID-19 patients in their own homes but this was the first time it was to be enacted for COVID-19 in a residential aged care facility.

All Newmarch House staff and residents were tested for COVID-19 on 14 and 15 April 2020, which resulted in nine residents and seven staff being diagnosed with COVID-19. As a result, 40 of 90 Newmarch House staff were furloughed to home-isolation or quarantine. Even after deployment of the surge workforce, this led to a sudden and serious shortfall of staff, especially considering the increased workload associated with the strict IPAC measures required. Subsequently, frequently repeated testing

allowed rapid identification of cases and revealed the increasing magnitude of the challenge.

Key Learning: to ensure the earliest possible identification of all COVID-19 cases, the immediate and repeated testing of all residents and staff should be implemented as soon as a single case is identified (as occurred at Newmarch House).

Daily teleconferences began on 15 April 2020, to share information and monitor the course of the outbreak at Newmarch House. Participants in these teleconferences varied but included representatives of some or all of the Commission, DoH, Nepean Blue Mountains PHU, NSW State Health Operations Centre (SHEOC), Nepean Hospital specialists and Anglicare. At the first teleconference, the Commission's Chief Medical Advisor recommended that COVID-19-infected residents be moved to another facility, to ease the load on the depleted workforce and reduce the ongoing risk to staff and other residents from COVID-19. Various options were considered, including a private hospital or alternative aged care home. This was vehemently opposed by Professor Branley because of the potentially traumatic effects of transfer on residents, the heightened risk of spread of COVID-19 and difficulty accessing appropriately skilled staff in other facilities. He also rejected the alternative of moving COVID-19 negative residents, on the grounds that some would be incubating infection and would soon become positive, which proved correct. This disagreement left Anglicare senior management with a dilemma. They had been reassured by Professor Branley's experience and willingness to assume clinical responsibility for care of COVID-19 patients but uncertain as to which advice had precedence. Following discussion between the relevant stakeholders, it was decided that the original plan should proceed.

Key Learning: at the outset, there must be a clear operating protocol in place, outlining the relevant stakeholders, their respective roles and the hierarchy of decision making, **noting** that the Approved Provider retains its obligations under the Aged Care Act 1997, unless there is a superordinate provision or order in place. The protocol should also address: meeting agenda, objectives, identification of participants, administration, documentation and meeting etiquette.

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. By the end of the first week (18 April 2020), 26 residents and 14 staff had been diagnosed with COVID-19 and 87% of the Anglicare frontline personal carers and nursing staff, including most of the surge team, had been furloughed to isolation or quarantine. In many cases, the decision to quarantine staff was based on a judgment that use of PPE recommended at the time was inadequate or because of contact between staff members without physical distancing or PPE.

Meanwhile, two Newmarch House facility managers had been replaced by managers from elsewhere in the Anglicare organisation, who were faced with the daunting task of establishing control, in the setting of an increasing caseload and serious staff and PPE shortages. 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.

Regulatory interventions and Anglicare Response

Anglicare and Newmarch House managers were increasingly burdened by requests for information arising from frequent daily teleconferences, including line-listings of cases and details of the status of individual residents. Many of these requests were triggered by numerous complaints to the Commission by anxious relatives, unable to contact Newmarch House. Senior Anglicare managers themselves had difficulty accessing clinical information because on-site managers and staff were overwhelmed by the pressure of providing care and unable to provide regular reports to residents' relatives or gather the information requested.

Anglicare managers, who participated in these teleconferences, reported frustration about conflicting advice from different agencies and the lack of clarity about the hierarchy of authority. Teleconference participants failed to identify themselves or the agency they represented and no minutes or action items were distributed to confirm or clarify the information or actions required. On the other hand, 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.

This accumulation of problems, led to the appointment of an external management team from BaptistCare on 23 April 2020, the Commission's decision to issue regulatory notices and the appointment of an external advisor. In early May, a Family Support Program was established and a review of IPAC practice by the NSW Clinical Excellence Commission requested. Anglicare and Newmarch House managers and the Anglicare Board acknowledged the value of these interventions which provided them an opportunity to re-establish a strong management team and implement much needed improvements in communications, resident care and IPAC. However, they also felt that the challenges they faced, some of which were beyond their control and the excessive burden on staff and on-site managers, had been inadequately recognised.

Leadership & Management

One of the constant features of commentary during the course of the interviews was that it was often unclear who was in charge at Newmarch House. There was a sense that there was no command structure in place, along with a perception that senior managers were working remotely and that Anglicare leadership was absent “on the ground”. Whilst some senior managers were working remotely, there was no lack of managers on site. However, frequent changes in the management team and the fact that many managers were new to their roles, contributed to the impression of instability. There was a parallel view from senior leaders that they wanted to provide the best people to manage the changing situation and create space for those managing the response at the home. In addition, the managers were often charged with tasks requiring urgent follow-up, including accessing supplies or implementing improvements, which were best managed away from the centre of the outbreak. Newmarch House managers on site were supported by senior managers throughout, several of whom were rapidly deployed into on-site leadership roles. The reviewers noted that CEO, Grant Millard, first attended the home on Monday, 13 April 2020.

The lack of clarity as to who was in charge was exacerbated by the fact that the daily interagency meetings were conducted by teleconference. They provided an opportunity for all participants to exchange information, make decisions and receive reports. On occasions, there were open and frank disagreements with varying opinions on how to proceed, given that the scale of this outbreak had not been experienced previously in Australia. This added to rising tensions. As such, the meetings were often not conducive to the collaboration required to work through and address issues in a timely and considered manner. The daily meeting schedule during the outbreak was onerous and included site meetings, interagency briefings and Anglicare’s Crisis Management Team meetings. Many staff reflected on the significant amount of time required to prepare for meetings and respond to requests for additional information. The Board was regularly briefed by the CEO, who was involved in the daily CMT and interagency meetings.

A further challenge was the number of government agencies involved, some of which residential aged care providers would not usually interact with on a day-to-day basis. The lack of clarity about the function of each agency and where it sat in the hierarchy of decision-making, added confusion to the burden of an already stressed situation and highlighted the complexity of decision-making.

Key Learnings: (i) the Approved Provider should identify and be ready to deploy its Outbreak Response Team (however titled); (ii) the Approved Provider should designate the leader of its Outbreak Response Team who is duly authorised to lead and make decisions on behalf of the Approved Provider; (iii) the Approved Provider should nominate its clinical leader who will provide clinical leadership and advice to the Approved Provider as part of its Outbreak Response Team.

The stress of the situation and the personal toll on the health of those managing the outbreak was reportedly palpable and contributed to the multiple changes in leadership at Newmarch House and in the broader Anglicare team supporting the outbreak. The reviewers noted that there is no designated clinical leadership position within the Anglicare Executive Team or any Executive Team member with a clinical background. They also identified many senior staff who were actively involved in outbreak. However the lack of clarity about leadership was of concern to external agencies, especially the Commission, which has regulatory oversight of the health, safety and welfare of the Newmarch House residents.

The Commission issued an Administrative Direction to Anglicare on 23 April 2020 requiring it to engage an external management team from the BaptistCare. This team of three senior managers had had previous experience with the first Australian COVID-19 outbreak at the Dorothy Henderson Lodge. Anglicare agreed cooperatively to this arrangement, recognising that guidance was required and that there was already mutual respect between the Approved Providers. The BaptistCare team arrived the following day, on Friday 24 April 2020 and feedback indicated, unequivocally, that this was a welcome turning point in the management of the outbreak at Newmarch House.

The BaptistCare team quickly assumed control and worked with the existing team at Newmarch House. They rapidly introduced significant improvements in staff management, the delivery and organisation of care and IPAC. Following implementation of the BaptistCare team's recommendations, the plan was to then transition to a newly consolidated leadership team at Newmarch House.

Andrew Kinkade, an experienced General Manager in residential care, was appointed as adviser to Anglicare under the terms of a *Notice to Agree* issued by the the Commission on 6 May 2020. After a period characterised by turmoil and upheaval, his appointment provided stability and enabled a focus on setting a forward agenda. He worked closely with the Newmarch House leadership team, the executive group, the CEO and the Board.

Communications

Throughout many review discussions and interviews, it was clear that communication was a major challenge for all involved with the outbreak. Concerns or queries from family members, which may have been otherwise easily resolved, became much more significant in the absence of effective, two-way communication. 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 make contact with Newmarch House.

It was also clear that Newmarch House and the broader Anglicare infrastructure struggled with the demands of managing copious inbound and outbound communications. 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.

The reviewers invited feedback from Newmarch House family members of both current and deceased residents. Whilst many issues were raised by family members, one of the most significant was the failure of effective communication. Notwithstanding this, family members were quick to recognise the magnitude of the day-to-day challenges at Newmarch House, whilst also reporting that sometimes, their concerns were dismissed or they were given incorrect information.

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.

Key Learning: access to advocacy services should be a priority during an outbreak. Advocates can assist providers and residents (or their legally appointed representatives) to resolve issues expeditiously.

Anglicare endeavoured to send regular emails to the nominated contact person for each resident but by their own admission and reports from some relatives, this was not always achieved. The process highlighted shortcomings in maintaining up-to-date information for each resident’s family. Early updates to residents and families from Anglicare acknowledged the importance and priority of improving communication with families but failed to do so for some time. Individual mobile phones were provided for the use of all residents (with assistance as required), whilst some already had mobile phones and others had landline phones installed in their rooms.

Key Learnings: (i) the Approved Provider should be responsible for maintaining an Emergency Contact Register for each resident. A minimum of three contacts may be registered. These contacts must be confirmed by the resident or their legally appointed representative; (ii) there should be a legally enforceable provision to share this Emergency Contact Register information with the Aged Care Quality and Safety Commission in the event that this is required to assist with improving emergency management.

However, whilst staff in Newmarch House were consumed appropriately with delivering person-centred care, the initial difficulties in providing effective communication compounded the concerns of distressed family members. During the first three weeks of the outbreak, there was increasing concern and disquiet from the families of residents, who wrote an open letter outlining their concerns to CEO, Grant Millard. This email was sent late on 28 April 2020 “on behalf of families and friends of Newmarch” and copied to news outlets and Members of Parliament, including the Ministers for Health and for Aged Care and Senior Australians.

Responding to increasing concerns, the Commission approached Andrew Kinkade, to support Anglicare in addressing the families’ growing disquiet. With the endorsement of his employer, Catholic Healthcare, he commenced in this role on Thursday 30 April 2020. He worked with an experienced crisis team leader (on secondment from Services Australia) and a newly formed team of dedicated clinical support staff. Together, they established the Family Support Program quickly and effectively, which was very much welcomed by family members. Within a very short period of time, communication protocols were established and communication improved dramatically. Early feedback from families was encouraging.

Key Learning: communication is a key priority and yet it is often underestimated. A communication protocol should be developed and highlight stakeholders, type of communication to be employed and frequency.

The experience at Newmarch House highlights, *inter alia*, the balance required between managing day-to-day operations, emergency management, the delivery of person-centred care and the importance of effective communication in a crisis. 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.

Staffing

Providing sufficient, appropriately skilled staff to manage and deliver person-centred care to residents at Newmarch House, proved to be one of the most significant challenges during the course of the outbreak. From the time the first staff member tested positive for COVID-19 on 11 April 2020, case numbers among staff steadily increased until 12 May (day 31), with 34 cases, whereas spread of COVID-19 to residents had ceased by 30 April (day 20), with 37 cases.

Early in the outbreak, many Newmarch House staff were identified as close contacts of confirmed cases and required to self-quarantine. This severely depleted the Newmarch House care workforce (registered nurses, enrolled nurses and personal carers). The situation was magnified by initial confusion about the correct use of the required PPE when caring for residents who had not been identified as positive cases. This resulted in more staff being required to self-quarantine, if these residents were later diagnosed with COVID-19.

Whilst most remaining staff continued to provide care, it was reported consistently that many were fearful of entering a COVID-19 outbreak workplace. This led to increased absenteeism, as well as last-minute cancellation by agency staff arriving on site but unaware that there was a COVID-19 outbreak at Newmarch House. Such was the unusual nature of the staffing issues, it was also reported favourably that some staff rose to the occasion and assisted with the delivery of direct resident care, even though they would not normally be engaged in direct care roles.

Ancillary staff were also affected and the impact on food services at Newmarch House was significant. Food supplies were threatened as agency contractors required documentation of COVID-19 workplace compliance to permit deliveries to occur and agency chefs were engaged to fill roster gaps. This would later affect the quality of the meal and food service provided to residents.

In preparing for a potential outbreak and anticipating shortfalls in workforce capacity, Anglicare had recruited staff to its own surge workforce. Training had commenced but during the first few days of the outbreak, approximately 50% of this group was also depleted because of infection or contact. This placed further strain on the availability of staff who were familiar with Newmarch House residents and Anglicare procedures. A review of the roster summary provided by Anglicare, confirmed the impact of staff in quarantine or isolation. In the first five days, there was a 25% reduction in rostered shifts worked, the effect of which was exacerbated by a significantly increased acuity of residents and workload. As indicated above, the worst day was 20 April 2020, with the combined loss of Anglicare's own staff, delayed availability of agency staff and many rostered staff simply failing to attend or cancelling at the last minute. After this period, the average number of rostered daily shifts worked gradually increased. By 30 April 2020, it peaked at 89, effectively more than doubling the regular care roster (37 rostered daily shifts), although the proportion of remaining Anglicare staff was low, relative to the increasing number of agency staff.

Key Learning: (i) Approved Providers should consider surge workforce capacity on the premise that a minimum of 50% of its staff may be furloughed; (ii) The Department of Health should consider expanding its surge workforce capacity providers in order to provide scaled support for individual Approved Providers.

Anglicare initially rejected offers to utilise the Department of Health’s surge workforce program (via Aspen Medical and Mable®) on the basis that some of these staff were reportedly unsuitable or that it would be able to source its own staff. They successfully utilised several other agencies to bolster the workforce during this challenging time. During the outbreak period, Aspen Medical and Mable® provided less than 20% of the non-Anglicare care workforce with the remainder sourced from other agencies, including St Vincent’s Hospital, which assisted specifically with the provision of Registered Nurses.

Mable® was unable to meet the urgent requirement to identify appropriately credentialed staff. It was reported by a Newmarch House manager that an initial review identified that, of 64 “expressions of interest”, there were just four suitable staff. Workplace insurance for Mable® contractors also proved challenging and this required Anglicare to purchase additional insurance cover for staff working at Newmarch House. It was also acknowledged that the Mable® platform had not been previously involved in residential aged care and there were a number of teething issues. Notwithstanding these, Mable® reportedly welcomed feedback and worked proactively with Anglicare to assist in addressing their staffing shortfall. Despite the overall higher acuity and workload demand, the reviewers were told that many agency staff rostered during the outbreak, had little or no experience working in aged care.

Anglicare provided a two-hour induction for all new agency staff when they commenced work at Newmarch House. This was undertaken by workplace trainers and included donning and doffing PPE (demonstration and competency assessment), fire and other emergency training, incident escalation and mandatory reporting. Whilst orientation was important, it also left a significant gap in the workforce during that two-hour period.

Key Learning: orientation for all new staff during the course of an outbreak is required and must include practical infection control training, instruction and a competency-based assessment of PPE donning and doffing, on a background of regular infection control training.

Following the appointment of the Baptistcare team on 24 April 2020, one of the first changes was to implement 12-hour rostered shifts, with the aim of limiting opportunities for spread of COVID-19 between staff members. This new roster commenced on 2 May 2020.

Throughout the course of the outbreak, the care team was supported by many staff from within and outside Anglicare including ancillary, lifestyle, pastoral care, allied health, doctors, hospitality, cleaning and maintenance staff.

Family members often commented positively on the availability of lifestyle staff and pastoral carers to support communication between them and their loved ones. The recruitment and deployment of physiotherapists and psychologists was also reported as a welcome resource, assisting with the reablement of residents who had become more isolated and frail during the course of the outbreak.

Key Learning: deconditioning of older people is a known complication of reduced activity and isolation. Approved Providers should consider specialist staffing requirements and activities to specifically address and enable maximum independence and reablement during an outbreak.

Medical and clinical care of residents

Rationale

As outlined earlier, the Director of Infectious Diseases at Nepean Hospital, Professor James Branley, visited Newmarch House on 12 April 2020. His decision, to admit residents with COVID-19 to Nepean Hospital's HITH program, was reinforced by his personal experience of the COVID-19 outbreak at Dorothy Henderson Lodge, management of COVID-19 patients in their own homes via HITH and the Geriatrics Department's established links with Newmarch House, through its virtual aged care service (VACS), led by Dr Anita Sharma. For frail elderly people, admission to an acute hospital, where most staff have limited experience of their complex care needs, can be extremely distressing. Caring for residents in an aged care home, during an infectious disease outbreak, was also the preferred option of public health authorities, so long as their medical needs, including IPAC, could be met.

Implementation of hospital-in-the-home and virtual aged care service

Despite the advantages of HITH, there were significant impediments to its successful implementation at Newmarch House, the most significant of which was a shortfall in staff familiar with the regular care needs of residents. In addition, the increasing numbers of COVID-19 positive residents in the home were a continued source of infection to other residents and staff because of imperfect IPAC practices, including cohorting. Another important issue was a lack of adequate provision for medical care of the majority of residents who remained COVID-19 free, noting that this was not the responsibility of the HITH program.

During the first two weeks of the outbreak, the VACS 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 said if they really needed to come to hospital we'll bring them to the hospital."*

Key Learning: misunderstandings and gaps in information exchange between doctors and patients or their relatives are common. Information often needs to be repeated and/or provided in written form. These misunderstandings are likely to be amplified in the context of an outbreaks crisis and especially when they touch on end-of-life care.

Anglicare managers unfamiliar with the HITH program were also told that it would provide equivalent care to that available to inpatients, except for ventilation and assumed that additional nursing support would be provided by Nepean Hospital to support this. Specialist medical support was provided on site, particularly via telehealth and HITH, VACS, palliative care and other Nepean Hospital specialists but there was no additional nursing support for HITH patients or general medical support for COVID-19 negative residents, until later. These shortfalls in nursing and medical support and the increased burden on carers of unfamiliar PPE, led to shortfalls in hospital-standard care for some residents with COVID-19 and neglect of or delays in, routine care of many others. Until COVID-19 positive residents were cohorted in one section the home, with dedicated staff, they were a continued source of infection.

In addition, the expectation that many residents with COVID-19 would require palliation meant that end-of-life medications were prescribed, for administration *prn* (as required). As a result, a much larger quantity of restricted (Schedule 8) drugs, than Newmarch House would normally store on site, was delivered on a Friday evening, creating an acute problem of finding adequate locked storage space in which to store them.

Key Learning: HITH is an attractive model of care for management of a COVID-19 outbreak in an aged care facility but the precondition of resident safety is only likely to be met if the outbreak is limited to a small number of cases in residents and staff.

The reviewers concluded that successful adoption of HITH as a model-of-care, for a large number of residents with COVID-19 in an aged care facility, is very challenging. It means that a comfortable, home-like setting has to be temporarily converted into one with hospital-level environmental controls, equipment, IPAC practices, pharmacy services and staff to ensure the safety and adequate care of all residents.

On the other hand, it has been shown that small numbers of COVID-19 patients can be managed safely and palliated, if necessary, in the familiar comfort of their home and potentially, with loved ones able to visit, with support and supervision of staff.

Key Learning: 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.

Role of general practitioners

Local general practitioners had an important but probably under-utilised role in the early weeks of the outbreak. Those who regularly cared for residents at Newmarch House were not immediately informed of the outbreak even when their patients were infected. However, 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. 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. They were even more frustrated, later, when they were unintentionally denied access to the electronic resident record system, iCare, which was replaced, temporarily by paper-based records. This decision had been made in light of the number of staff who did not know how to use this electronic resident record system. As a result, general practitioners could not provide timely information to relatives about residents who were diagnosed with or had died from, COVID-19. They could not monitor their patients' condition, prescribe medications or renew prescriptions. It was soon recognised that on-site general practitioners would be required but it took some time before locum medical staff could be recruited.

Key Learning: GPs are an underused resource during a COVID-19 outbreak in an aged care facility but their participation (and interaction with families) requires good communication and access to patient information.

Clinical Care

Variable quantity and capability of nursing and care staff, challenged an already complex environment. During the period of the outbreak, there were some clinical

incidents including medication errors, pressure sores and skin conditions. The lack of access to iCare resulted in a diminished capacity to identify care delivery issues in a timely manner. Alternative handover and care plan documentation had to be formulated in the absence of electronic records. In addition, automated system alerts and the subsequent capacity to follow-up immediately on them was lost. In some cases, this led to delayed clinical or care responses and adverse outcomes for residents. Later, temporary Nurse Unit Manager positions were installed to direct care in each of the designated areas. Nursing care was also complemented by allied health staff who contributed to the reablement of increasingly frail and isolated residents.

Key Learning: Approved Providers should consider the implications of a loss of Electronic Records as part of its Business Continuity Plan. Access and implications for all parties using the electronic records should be considered.

Infection prevention and control (IPAC)

Background

The understanding and practice of IPAC in healthcare and especially aged care is highly variable and often suboptimal, despite recently revised accreditation standards in both sectors. IPAC principles are straightforward but their implementation is context-specific and often requires the expertise of an experienced IPAC professional, particularly in an unusual situation, such as a novel infectious disease outbreak in an aged care facility. Health and aged care administrators and regulatory authorities often misunderstand or underestimate the infrastructure and training required to prevent microbial transmission, in environments where vulnerable patients or residents depend on hands-on care from busy, peripatetic workers. This lack of awareness of what IPAC involves was described, during this review, by an IPAC specialist: *'...infection control rolls off people's tongues, but they don't really understand what it means. And they certainly don't understand how to implement it and ... how to continually interrogate and resolve the issues that people come up with ...'*. In the absence of an obvious threat or active surveillance, breaches of IPAC practice are often hidden and relegated to a lower priority than the more immediate demands of person-centred care. However, they will be rapidly exposed and difficult to remedy, in the face of an infectious disease emergency.

Anglicare COVID-19 IPAC preparedness

Anglicare had commenced organisation-wide preparations for outbreak management including additional IPAC training for staff before the COVID-19 outbreak began. Its Infection Control Policy, with updates in June 2019 and June 2020, outlines organisational accountabilities and links to online resources including

its 'primary resource for infection control information'- the *Bug Control Infection Control and Prevention eManual* - but provides no practical detail about how IPAC should be applied in the setting of an infectious disease outbreak. It is difficult to assess the content or effectiveness of Anglicare staff training or their compliance with IPAC protocols and procedures. However, the review was told that Anglicare managers and staff were familiar with and had successfully managed previous influenza and gastroenteritis outbreaks. Additional IPAC training was included in the half-day training for the COVID-19 outbreak surge team. This training had been completed by 30 Anglicare staff when the COVID-19 outbreak began at Newmarch House on 11 April 2020.

IPAC during the COVID-19 outbreak at Newmarch House

At the commencement of the outbreak, the Nepean Hospital IPAC clinical nurse consultant, visited the home briefly and provided general IPAC advice. Professor James Branley, who was on site on most days provided on-going advice. The Nepean Blue Mountains PHU officers were responsible for contact tracing and decisions about whether individual staff members were close-contacts requiring quarantine. This was based on interviews of staff to ascertain when they had cared for a COVID-19 positive resident and whether they were wearing adequate PPE at the time and/or when and in what circumstances they had been in contact with a fellow staff member who developed COVID-19. This process was not always straightforward: sometimes there were delays in contacting agency staff, whose contact details were not always known to Newmarch House; there were uncertainties about how long COVID-19 positive residents or staff were infectious, before the diagnosis was confirmed and some staff were uncertain or unable to recall what PPE they had been using during potential contact. When in doubt, public health officers, understandably in the circumstances, erred on the side of caution. However, their decisions had major implications for staffing and IPAC.

There were differences of opinion and changes over time, in instruction for use of PPE and there was no ongoing expert IPAC leadership or supervision. Consistent adherence to basic IPAC principles, including physical distancing, hand hygiene and appropriate use of PPE, was complicated by the rapid depletion of staff. The IPAC training and competency of agency staff who were recruited was highly variable or unknown. Daily on-site orientation for new agency staff was conducted by Anglicare educators and workplace trainers and briefly covered aspects of IPAC. However, some agency staff reported having received no IPAC training at Newmarch House. 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 and they were soon fully occupied with clinical care.

Among the IPAC issues identified during this review, was the continuous, unnecessary use of 'full' PPE (gowns, gloves, masks) in non-clinical 'clean' areas such

as the entrance foyer, offices and staff rooms and failure to change to fresh PPE on entry to the rooms of COVID-19 negative residents. This represented a risk to other residents and staff, if one of these residents was later diagnosed with COVID-19 and potentially infectious, before the diagnosis was confirmed. Later when there were shortages, full PPE was restricted to care of residents with known COVID-19. These inconsistencies of use and the poor quality of some PPE meant that staff who had been caring for residents, before they were diagnosed with COVID-19, were automatically deemed to be close contacts and quarantined, sometimes possibly unnecessarily.

Key Learning: establishing effective infection prevention and control is time-critical. Lack of consistent expert IPAC guidance at the start of the outbreak led to inconsistent use of PPE and uncertainty about exposure of staff contacts to COVID-19 positive cases.

Apart from inconsistent use of PPE, other reasons for the rapid depletion of staff numbers, were frequent instances of staff-to-staff contact due to a lack of physical distancing during meal breaks, at meetings, when sharing transport to and from the workplace or when socialising in groups after hours. In these situations, PPE was not indicated so long as physical distancing was maintained. Although staff were instructed to stay at least 1.5 metres away from others when not using PPE, some apparently disregarded, misunderstood or found it difficult to follow this instruction. The fact that maintaining physical distancing was difficult, in some circumstances, was not appreciated by agency staff employers. For example, some agency staff were transported to and from Newmarch House in buses or shared taxis or had to wait in line for swabs to be taken for COVID-19 tests at the beginning of a shift. These breaches of physical distancing were undoubtedly responsible for some staff being infected with COVID-19 but a much greater number were quarantined but did not become infected.

Personal protective equipment

Early in the outbreak, after their own stocks of PPE were rapidly depleted, Anglicare had difficulty acquiring adequate supplies from the national medical stockpile or NSW HealthShare. This was partly because the quantity being used at Newmarch House was greatly in excess of departmental supply officers' estimates of the amount needed, based only on the number of COVID-19-positive residents, as well as sometimes unnecessary use of PPE at Newmarch House. Anglicare also had difficulty purchasing adequate supplies of suitable PPE privately.

It was reported by on-site managers, agency staff and later by an IPAC review, that the quality of many items of PPE was inferior, including: vinyl rather than nitrile gloves; plastic aprons, non-impermeable gowns and gowns than opened at the front and non-standard respirators (masks). Early in the outbreak, it was decided that P2/N95 respirators would be used routinely at Newmarch House, although national

and NSW IPAC guidelines recommended ‘contact and droplet precautions’ (implying surgical masks) for care of COVID-19 patients. Global shortages of P2/N95 respirators meant that supplies from national and NSW stockpiles were restricted to use in approved settings, mainly in hospitals. Those sourced privately were often of inferior quality, difficult to wear (poorly fitting and prone to falling off) and available in a limited range of sizes. It is unlikely that many (if any) staff had been trained in the correct use of P2/N95 respirators, which require them to be fit-checked with each use and removed carefully to prevent self-contamination by the wearer. The additional workload, associated with frequent PPE changes was exaggerated, not only by its use when not required but also by unnecessary use of caps and overshoes.

Until they were rectified, staff and PPE shortages and the presence of COVID-19 positive residents in different zones of the home, undoubtedly contributed to IPAC breaches and ongoing transmission of COVID-19.

NSW Clinical Excellence Commission IPAC Review

On 1 May 2020, a review of IPAC practices at Newmarch House, led by the senior IPAC manager from the NSW Clinical Excellence Commission (CEC), identified significant problems for which remediation was recommended. Among the issues that could have resulted in IPAC breaches was the fact that the number of staff supplied by up to 10 different agencies had been augmented to a point where there was crowding and frequent neglect of physical distancing in communal areas. Restrictions on staff movements and the use of designated zones were implemented. Additional training was introduced to correct IPAC knowledge gaps, poor hand hygiene compliance and inconsistent use of PPE. The team’s recommendations also included: removal of clutter; delineation between ‘clean; and ‘dirty’ zones; strategic placement of signage and replacement of unsuitable hand sanitiser and cleaning products. The team acknowledged that the home-like setting of a residential care facility (with carpets, soft-furnishings and residents’ belongings) was a challenging physical environment in which to implement hospital-level IPAC measures but demonstrated how to apply IPAC principles more effectively.

Response to Clinical Excellence Commission’s Review

The BaptistCare management team, who arrived at Newmarch House on 24 April 2020, had already begun to implement some of the measures recommended by the CEC review team. These included zoning and internal cohorting of COVID-19-infected residents into one zone, with separate staff teams for COVID-19 positive and negative residents. The complex and sensitive task of moving some residents into different rooms was accomplished with the full cooperation of Anglicare and Newmarch House managers. Physical distancing of staff was more closely monitored; recommended standard and transmission-based (contact and droplet)

precautions were implemented; signs were laminated and placed strategically throughout the home; staff competence in donning and safe removal of PPE was assessed regularly; the use, distribution, ordering and stock control of PPE were rationalised and unsuitable items replaced; nurse unit managers and IPAC champions were assigned to each of six residential zones; showering of residents, with appropriate PPE, was reintroduced; protocols for enhanced environmental cleaning and decontamination of equipment were developed and storage and removal of waste and soiled linen were standardised.

Notwithstanding the challenges, many of which were beyond the control of Anglicare management, the IPAC-related issues identified by the CEC review could have been mitigated by involvement of an experienced IPAC professional at the start of the outbreak. This would, almost certainly, have resulted in more efficient and consistent use of limited resources (staff and PPE) and possibly, fewer COVID-19 cases.

Family Experiences

An invitation to participate in the review was facilitated by Anglicare and with support from the Older Persons Action Network (OPAN), an invitation was also posted on the Facebook page of the “Newmarch Family & Friends” group. OPAN engaged proactively with Anglicare, early in the outbreak, to introduce its service and support networks and whilst this was resisted initially, it was later welcomed. OPAN staff sensed that the initial delay was due to Newmarch House managers being appropriately fully focused on care of residents and the operational demands of the outbreak.

Prior to the implementation of the Family Support Program, OPAN facilitated support from a team of Senior Rights Service advocates on site, who were ready and available to work with Newmarch House families. OPAN initially experienced delays in being able to access nominated contact person details, in order to engage with family members directly. There was concern that this added to the trauma already experienced by families and further isolated residents. When on site, the advocates also experienced delays in accessing timely information for families and often had to call the Anglicare 1300 call centre (and wait in a queue) to receive information and be able to respond to the concerns of family members. Advocates reported that many family members were upset during the video-calls with their loved ones, often observing some cognitive or physical decline or apparent lapses in care.

Written feedback to the review was received and a series of individual family interviews conducted. As noted earlier, issues related to communication were pervasive in interviews with Newmarch House families and whilst there was a number of other concerns raised during the meetings, many of those interviewed also spoke positively about care and services during non-outbreak times. Family

members discussed the high regard in which Newmarch House was held in the local community as well as reflecting positively on why it had been the home of choice for their loved ones. Some felt that the home had been unjustly demonised and staff vilified in media reports. Others family members indicated that the prolific adverse media attention, had added to their own, already high, levels of stress, guilt and helplessness.

Family members complained about the number of unanswered calls, emails and messages and in some cases, the lack of already agreed follow-up. This was reported as a particular point of frustration in the early days. Given the coverage and prominence of regulatory interventions and references to the potential revocation of Anglicare's provider approval, some family members also feared that the home would be forced to close.

The establishment of the Family Support Program (FSP) in early May was recognised as a turning point by many family members, as it established daily communication updates and interactions with the nominated contact person for each resident. The FSP team members were allocated to groups of residents in order to provide consistency and continuity with both staff and family members. Whilst the feedback was overwhelmingly positive, some family members said that they occasionally received discrepant reports from the FSP team members and their loved ones living in Newmarch House.

Key Learning: 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.

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. As a result of a shower ban in the early period and a prevailing view that showering may risk spread of COVID-19, family members also reported concerns about hygiene for residents unable to take a shower or wash their hair.

There was considerable feedback about the quality of the food provided during the outbreak with reports of resident being given frozen sandwiches, cold or inedible meals and delays in meal service delivery. Due to IPAC requirements, meals were

served on paper plates and with disposable cutlery, which made them even less palatable.

Family members also commented on the impact of cohorting of residents on those affected by room changes. It was reported that despite assurances to the contrary, there were delays in reconnecting landline phones to the residents' newly allocated rooms. Family members also identified an emotional toll on residents, who were moved into rooms formerly occupied by friends, who had passed away during the outbreak.

Some families reflected on feeling pressured about making or reviewing advanced care plans for their loved ones and felt misled about what HITH and telehealth ultimately provided, compared with the option of hospitalisation. Families also reported that despite assurances about the availability of intravenous fluids and antibiotics in the HITH model of care, this was not always available when required. However, some families accepted that the HITH model provided the right level of care for their loved ones and in a setting they were familiar with.

Families were generally understanding and sympathetic to the plight of Newmarch House in that it was designed and built to be a person's home and not set-up as a hospital. They also recognised the considerable effort in endeavoring to meet the needs of the residents in the challenging environment.

In addition to the specific matters already outlined, some of the key issues raised by families in discussions with the reviewers were concerns related to:

- general quality and sufficiency of care being delivered;
- poor infection control;
- delays in bed linen changes and personal laundry;
- difficulty in being able to identify staff members whose faces were obscured by masks and not wearing name badges;
- provision of adequate nutrition and hydration;
- difficulty in communicating with and understanding some staff;
- provision of meaningful activities;
- changes in the level of general practitioner care their loved ones had previously received;
- whether or not they should have taken their loved ones home;

and the impact of these matters on the physical and emotional care of their loved ones as well as on their own mental health. Families were resolute in the need to increase the standard of training and education for all staff, in order to better manage such outbreaks in the future. Consistent with repeated public commentary, they also supported more registered and enrolled nurses in the aged care workforce.

Key Learning: residents' families consistently advocated and endorsed improvements in the number, mix and training of staff, supporting improved delivery of care to residents. The outbreak identified a pressing need to lift the standards of education and training in infection control. This feedback should be considered in light of relevant reviews previously undertaken and those currently underway.

Family members spoke positively of the role of the pastoral carers in Anglicare and the support they provided to residents and their families. However, there were some particular concerns from families with regard to the provision of end-of-life care support, their inability to be there to support their loved ones or confusion about when they could visit. One family reported having discussions with the treating doctor and making arrangements to visit, only to be denied entry on arrival as the resident was reportedly stable (and no longer met the criteria for a permissible visit). Through written feedback, family members also expressed disappointment with the management, decontamination and return of personal effects following a loved one's death. Despite assurances about the process, involving discussions with staff at Newmarch House, they reported that personal effects were returned unclean and simply bundled into a large plastic bag prior to being delivered to them.

Key Learning: consideration of how to facilitate improved closer physical contact with family members during end of life care must occur as a priority.

Key Learning: protocols should be developed to provide an authoritative source of guidance on the storage, decontamination and return of desired personal effects to family members following the death of a loved one.

Conclusions

Throughout April 2020, COVID-19 cases among residents and staff continued to increase, fuelling a vicious cycle of staff and PPE shortages, suboptimal IPAC practice, infection source-control and the resulting increase in workload and COVID-19 transmission. Nevertheless, most COVID-19 infections among residents occurred within two weeks and all within 20 days of the first case. However, infections among staff continued to emerge until mid-May, due to ongoing transmission, some of which occurred between staff or was acquired in the community.

By week four of the outbreak (early May), many of the early problems were being addressed, management structures were re-established, staff numbers increased, and the new Family Support Program in place. IPAC practices were improved and more education and training was underway. Resident and staff cohorting, into COVID-19 positive and negative zones was established, routine medical care was reinstated and measures to mitigate the adverse effects of prolonged isolation and/or illness of residents introduced.

Despite the multitude of challenges, many participants in this review praised the continued support, on-site presence and on-call availability of senior Nepean Hospital Infectious Diseases and Geriatrics specialists throughout this difficult time.

Many relatives were also grateful for the care provided to their loved ones in Newmarch House, most of whom appreciated being able to remain in familiar surroundings during the outbreak. However, care of residents was variable and staff and families observed care shortfalls, incidents and adverse outcomes during the course of the outbreak. A number of factors contributed to these deficiencies in care, including the high proportion of non-Anglicare staff who were unfamiliar with the Newmarch House environment; increasing acuity of residents care; competing demands on managers' time; temporary loss of the electronic resident record system and above all, variable levels of clinical leadership.

The HITH model was clearly contentious. However, it has many advantages for healthcare generally and is particularly attractive for residents of aged care facilities, for whom hospital admission is often distressing. Its success depends on adequate patient support in the home setting, which was not available at Newmarch House, in the early weeks of the COVID-19 outbreak.

The continued presence of residents with COVID-19 in the home, many of whom required a disproportionate share of limited nursing resources, were an ongoing potential source of infection, especially in the face of faulty IPAC practices. This could have been mitigated by early advice from an experienced IPAC professional. Outbreak control requires both source and transmission control.

Many family members recognised and were appreciative of the extended efforts of staff, who continued to provide care and comfort to their loved ones. However, this was often outweighed and overshadowed by the emotional enormity of living through the outbreak and in some cases, the grief of having lost a loved one.

It is clear to the reviewers that Anglicare spared no effort or expense in responding to one of the most significant crises to occur in the history of residential aged care in Australia. Overall, the ongoing care of vulnerable residents in the face of such difficult and unprecedented circumstances, is a credit to the tireless efforts of many Anglicare and Newmarch House managers, personal carers, nurses and support staff, in conjunction with the support of many Nepean Hospital specialists.

Discussions with the CEO and Board Directors confirmed their commitment to reflect and learn from the COVID-19 outbreak at Newmarch House. In turn, this will drive further organisation-wide improvements in leadership, clinical governance, care and service delivery.

At the commencement of this outbreak, Australia was on the brink of a steep learning curve about COVID-19 and its implications for aged care settings. The reviewers hope that this report will add to the existing body of knowledge and provide impetus for future improvements in aged care.

1. Problems with management need to be addressed as soon as possible after they are recognized;
2. To ensure the earliest possible identification of all COVID-19 cases, the immediate and repeated testing of all residents and staff should be implemented as soon as a single case is identified (as occurred at Newmarch House);
3. At the outset, there must be a clear operating protocol in place, outlining the relevant stakeholders, their respective roles and the hierarchy of decision making, **noting** that the Approved Provider retains its obligations under the Aged Care Act 1997, unless there is a superordinate provision or order in place. The protocol should also address: meeting agenda, objectives, identification of participants, administration, documentation and meeting etiquette;
4. (i) the Approved Provider should identify and be ready to deploy its Outbreak Response Team (however titled); (ii) the Approved Provider should designate the leader of its Outbreak Response Team who is duly authorised to lead and make decisions on behalf of the Approved Provider; (iii) the Approved Provider must nominate its clinical leader who will provide clinical leadership and advice to the Approved Provider as part of its Outbreak Response Team;
5. Access to advocacy services should be a priority during an outbreak. Advocates can assist providers and residents (or their legally appointed representatives) to resolve issues expeditiously;
6. (i) the Approved Provider should be responsible for maintaining an Emergency Contact Register for each resident. A minimum of three contacts may be registered. These contacts must be confirmed by the resident or their legally appointed representative; (ii) there must be a legally enforceable provision to share this Emergency Contact Register information with the Aged Care Quality and Safety Commission, in the event that this is required to assist with improving emergency management;
7. Communication is a key priority and yet it is often underestimated. A communication protocol should be developed and highlight stakeholders, types of communication and frequency;
8. (i) Approved Providers should consider surge workforce capacity on the premise that a minimum of 50% of its staff may be furloughed; (ii) The Department of Health should consider expanding its surge workforce capacity providers in order to provide scaled support for individual Approved Providers;
9. Orientation for all new staff during the course of an outbreak is required and must include practical infection control training, instruction and a competency-based assessment of PPE donning and doffing, on a background of regular infection control training.
10. Deconditioning of older people is a known complication of reduced activity and isolation. Approved Providers should consider specialist staffing requirements and activities to specifically address and enable maximum independence and reablement during an outbreak;

11. Misunderstandings and gaps in information exchange between doctors and patients or their relatives are common. Information often needs to be repeated and/or provided in written form. These misunderstandings are likely to be amplified in the context of an outbreaks crisis and especially when they touch on end-of-life care;
12. HITH is an attractive model of care for management of a COVID-19 outbreak in an aged care facility but the precondition of resident safety is only likely to be met if the outbreak is limited to a small number of cases in residents and staff;
13. 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 those residents to return. **NB:** Implications of such decisions will need to be considered in light of individual resident's personal preferences.
14. GPs are an underused resource during a COVID-19 outbreak in an aged care facility but their participation (and interaction with families) requires good communication and access to patient information;
15. Approved Providers should consider the implications of a loss of Electronic Records as part of its Business Continuity Plan. Access and implications for all parties using the electronic records should be considered;
16. Establishing effective infection prevention and control is time-critical. Lack of consistent expert IPAC guidance at the start of the outbreak led to inconsistent use of PPE and uncertainty about exposure of staff contacts to COVID-19 positive cases;
17. 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;
18. Residents' families consistently advocated and endorsed improvements in the number, mix and training of staff, supporting improved delivery of care to residents. The outbreak identified a pressing need to lift the standards of education and training in infection control. This feedback should be considered in light of relevant reviews previously undertaken and those currently underway;
19. Consideration of how to facilitate improved closer physical contact with family members during end of life care must occur as a priority;
20. Protocols should be developed to provide an authoritative source of guidance on the storage, decontamination and return of desired personal effects to family members following the death of a loved one.

Appendix II

The Reviewers

Professor Gwendolyn (Lyn) Gilbert AO

MD FRACP FRCPA FASM MBioethics

Professor Lyn Gilbert is an Honorary Professor at the University of Sydney. Through medical training and postgraduate education, she is an Infectious Diseases Physician and Clinical Microbiologist with extensive research interests. She is currently a Senior Researcher at the Marie Bashir Institute for Infectious Diseases and Biosecurity, a Senior Associate at Sydney Health Ethics and Consultant Emeritus at Westmead Hospital.

Professor Gilbert has published more than 380 research articles as well as authoring several books and book chapters. Her main research interests are prevention, surveillance, control and the ethics of communicable diseases of public health importance. She was the inaugural Chair of the national Public Health Laboratory (PHLN) Network, is a former member of the Communicable Diseases Network of Australia (CDNA) and current Chair of the national Infection Control Expert Group (ICEG) which provides advice to the Australian Health Protection Principal Committee.

Adjunct Professor Alan Lilly

RPN RGN Grad Dip HSM MHA FCHSM FIML MAICD

Professor Alan Lilly is an Adjunct Professor with Australian Catholic University. He is a Registered Psychiatric Nurse and Registered General Nurse by background, with a Graduate Diploma in Health Services Management and Master of Business in Health Administration. With extensive experience in residential care, he has worked across the health, disability and aged care sectors and was Chief Executive for almost ten years in public and private sector organisations.

He is currently a Board Director of the Royal Women's Hospital and the Royal Victorian Eye & Ear Hospital in Melbourne and chairs their respective Board Quality & Safety Committees. A former Accreditation Surveyor with the Australian Council on Healthcare Standards, his professional interests are in leadership, quality & safety and the consumer experience. Nowadays, Alan is Principal of his own consulting firm, Acumenity, providing consulting services in Health and Aged Care.

Appendix III

Summary of Interviews and Written Submissions

No.	Date	Role or Department	Organisation
1	29 June	Infectious Diseases	Nepean Blue Mountains Local Health District
2	30 June	Senior Manager	Clinical Excellence Commission
3	30 June	State Manager	Department of Health
4	30 June	Public Health Physician PHEOC Public Health Physician Epidemiologist Nurse Unit Manager	NSW Health Nepean Blue Mountains LHD PHU
5	30 June	Executive Team Executive Team Executive Team	Aged Care Quality and Safety Commission
6	1 July	Clinical First Responder Group 1	Aspen Medical
7	1 July	General Practitioner	Newmarch House local GP
8	1 July	Clinical First Responder Group 2	Aspen Medical
9	2 July	General Practitioner	Newmarch House local GP
10	3 July	Clinical First Responder	Aspen Medical
11	6 July	Appointed Advisor	Catholic Healthcare
12	6 July	Public Health Physician	NSW Health
13	6 July	Geriatrician	Nepean Hospital
14	7 July	Executive Team Member COVID-19 Team Member COVID-19 Team Member COVID-19 Team Member	Older Persons Action Network
15	7 July	Executive Team Member Advocacy Support Advocacy Support Advocacy Support	Seniors Rights Service NSW
16	10 July	Team Leader Family Support Program	Services Australia Alliance Health
17	14 July	Public Health Executive	SA Health
18	15 July (NB: two meetings)	Management Team Management Team Management Team	Newmarch House
19	16 July	Chief Executive Officer	Anglicare
20	17 July	Quality and Compliance Management Team	Anglicare
21	17 July	Deputy Secretary	Department of Health
22	22 July	Executive Team Member	Anglicare
23	22 July	Resident Representative	Newmarch House
24	22 July	Resident Representative	Newmarch House
25	22 July	Resident Representative	Newmarch House
26	23 July	Resident Representative	Newmarch House
27	23 July	Resident Representative	Newmarch House
28	23 July	Resident Representative	Newmarch House
29	23 July	Resident Representative	Newmarch House
30	24 July	Quality and Compliance	Newmarch House
31	24 July	Resident Representative	Newmarch House
32	24 July	Resident Representative	Newmarch House
33	24 July	Resident Representative	Newmarch House
34	24 July	Executive Team Member	Anglicare
35	24 July	Resident Representative	Newmarch House
36	29 July	Board Director Board Director	Anglicare Anglicare
37	12 Aug	Quality and Compliance	Anglicare
38		Resident Representatives x 8 Written submissions	Newmarch House

NB: Names of individuals withheld for privacy reasons.