Independent Review

of COVID-19 outbreaks at

- **St Basil's Home for the Aged in Fawkner, Victoria**
- **Heritage Care Epping Gardens in Epping, Victoria**

Conducted by:

Professor Lyn Gilbert AO
Adjunct Professor Alan Lilly

30 November 2020

Acknowledgements

The reviewers would like to acknowledge all of the people who have participated in and supported, the Independent Review of the COVID-19 outbreaks at Heritage Care Epping Gardens and at St Basil's Home for the Aged. The review is richer for their insights, perspectives and contributions.

These outbreaks have taken an enormous personal toll on residents, their families and their friends. Tragically, many lives were also lost during this second wave of COVID-19 in Victoria. To all those families and friends who lost their loved ones during the outbreaks, we extend our sincere condolences.

These outbreaks have also significantly impacted the personal and professional lives of so many people, who work every day to support or care for people who live in residential care – those who work in or lead the residential aged care facilities, those who work in public and private health services, Commonwealth and state government agencies and advocacy organisations; our elected representatives and regulators. We acknowledge and thank them for their ongoing commitment.

This review is to give a voice to the many and varied perspectives and experiences which occurred during or arose as a result of, the above outbreaks which commenced in July 2020.

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Abbreviations

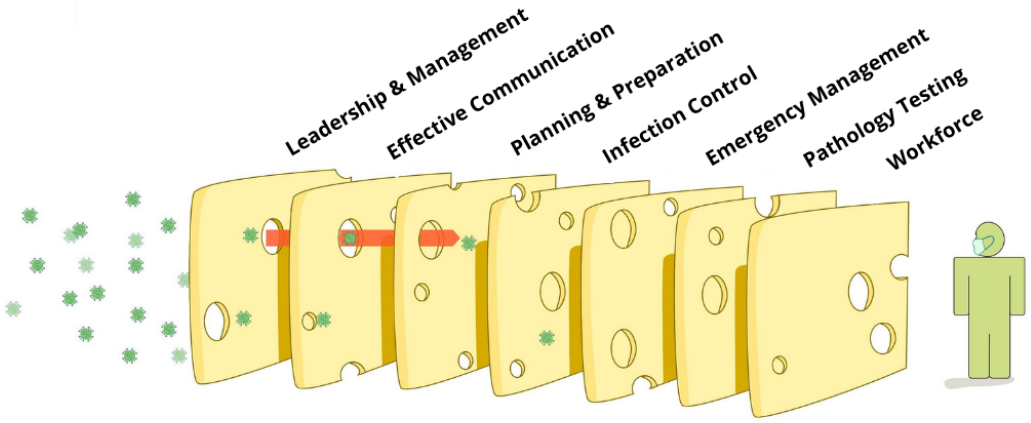
Abbreviations are used regularly throughout this document. Whilst the first mention of the abbreviation is explained, the following list summarises those most used:

ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADF	Australian Defence Force
CDNA	Communicable Diseases Network of Australia
CFR	Clinical first responder
CNMO	Chief Nursing & Midwifery Officer (Commonwealth)
CNO	Chief Nursing Officer (Austin Health)
DHHS	Department of Health and Human Services (Victoria)
DoH	Department of Health (Commonwealth)
DoN	Director of Nursing
EN	Enrolled nurse
HPRPD	hours per resident per day
IPC	Infection prevention and control
IPCON	Infection Prevention and Control Outreach Nurses
NTA	Notice to Agree
OMP	outbreak management plan
OPAN	Older Persons Advocacy Network
PCA	Personal care assistant
PHU	Public Health Unit (Victoria)
PPE	Personal protective equipment
RACF	Residential aged care facility
RiR	Residential in-reach (health services supporting residential care)
RN	Registered nurse
VACRC	Victorian Aged Care Response Centre

Foreword

Understanding the *Swiss Cheese* model applied to COVID-19 outbreaks

- recognising that no single intervention can limit spread on its own -



Each intervention (layer of cheese) has imperfections (holes)

- multiple layers improve likelihood of success -

Adapted from the work of
Ian M Mackay, 12 Oct 2020

Why apply the Swiss Cheese model to COVID-19 outbreaks ?

The *Swiss Cheese* model[1] of accident causation, originally proposed by James Reason, is used regularly to understand failures in healthcare and many other safety-focused environments. It likens human system defences to a series of slices of randomly-holed *Swiss Cheese* arranged vertically and parallel to each other with gaps in-between each slice. Reason hypothesises that most accidents can be traced to one or more of four levels of failure: organisational influences, unsafe supervision, preconditions for unsafe acts and the unsafe acts themselves.

In the *Swiss Cheese* model, an organisation's defences against failure are modelled as a series of barriers, represented as slices of the cheese. The holes in the cheese slices represent individual weaknesses in individual parts of the system and are continually varying in size and position in all slices. The system as a whole produces failures when holes in all of the slices momentarily align, permitting "a trajectory of accident opportunity", so that a hazard passes through holes in all of the defences, leading to an accident.

In this context, the COVID-19 outbreak at two Melbourne residential aged care facilities is “the accident” and this review seeks to understand which defence breakdowns occurred and what can be learned to improve service and care delivery into the future.

[1] *https://www.skybrary.aero/index.php/James_Reason_HF_Model*
[2] *data from “COVID-19 outbreaks in Australian residential aged care facilities^ October 23, 2020.*

Contents

Executive Overview

This Independent Review was commissioned by the Commonwealth Department of Health (DoH) to inquire into and learn from the two COVID-19 outbreaks at St Basil's Home for the Aged (St Basil's) and Heritage Care Epping Gardens (Epping Gardens) in Victoria (the facilities).

St Basil's and Epping Gardens are operated by Approved Providers within the meaning of the Aged Care Act 1997. Under the Act, Approved Providers have obligations and specific responsibilities for: (i) the quality of care they provide (ii) the user rights of people receiving care and (iii) accountability for the care provided. The Aged Care Quality and Safety Commission (ACQSC) monitors and assesses aged care service providers in accordance with the Aged Care Quality and Safety Commission Act 2018 and the Aged Care Quality and Safety Commission Rules 2018.

What occurred in Victoria, in July and August 2020, had not been witnessed before in Australia - a second wave of COVID-19 infections which directly affected more than 2,000 residents and more than 2,200 staff of residential aged care facilities (RACFs), across more than 200 outbreaks. The outbreaks at St Basil's and Epping Gardens took hold in the early stages of the second wave and were amongst the largest recorded. In commissioning the review, the Department of Health sought to understand not only what had occurred but more importantly, what could be learned, so that the aged care sector could respond and be better prepared in the event of future outbreaks.

Managing COVID-19 outbreaks in these two RACFs during the early stages of Victoria's second wave was often complicated by delayed results from over-extended contact tracing and laboratory testing services. Finding staff to replace experienced aged care staff, furloughed because of COVID-19 infection or close contact, was extremely challenging. In the context of rapidly increasing hospital admissions for COVID-19 and depleted staff numbers, acute care hospitals' capacity to accept transfers from residential aged care facilities, were necessarily limited to definite medical indications.

At St Basil's, 94 residents and 94 staff members were infected, and 45 residents died with COVID-19. At Epping Gardens, 103 residents and 86 staff were infected, with 38 resident deaths[2]. These stark numbers do not begin to convey the trauma and grief suffered by all residents, whether or not they developed COVID-19, and the enormous impact on their families. They do not account for the distress of staff members, who knew and had cared for residents for long periods but were quarantined and obliged to leave them in the care of "strangers". Many of the

[2] *data from "COVID-19 outbreaks in Australian residential aged care facilities^ October 23, 2020. https://www.health.gov.au/resources/publications/covid-19-outbreaks-in-australian-residential-aged-care-facilities-23-october-2020*

agency workers who replaced quarantined staff, came with little, if any, preparation or experience in aged care and were also deeply traumatised by the experience.

The review was undertaken by Professor Lyn Gilbert AO and Adjunct Professor Alan Lilly both of whom have prior experience in undertaking similar reviews. The reviewers consulted widely with multiple stakeholders throughout the course of the review and importantly, also met with families and residents. Whilst there were some legal impediments in executing the task, the reviewers gathered as much information as possible from many sources, including interviews, statements and documentation, in order to glean insights and formulate this report.

Continuing reflections on previous reviews at Dorothy Henderson Lodge and Newmarch House in New South Wales, the reviewers comment on their observations of ongoing improvements, challenges and opportunities, in managing COVID-19 outbreaks in residential care.

In keeping with the terms of reference, this review found that:

Emergency planning and preparedness *was inadequate*. Documentation and interviews *indicated poor planning* or planning which relied significantly on external (potentially already depleted) resources. The reviewers identified that having completed a self-assessment of any kind is no substitute for practicing or exercising a plan. Notwithstanding that any amount of planning may have been insufficient to manage the magnitude of these outbreaks, the limited planning included a low or absent level of self-sufficiency in the event of an outbreak;

Infection prevention and control (IPC) capacity and capability *were suboptimal* in these settings. Accreditation requirements (which had been met) were no match for a virus that could spread so rapidly in local communities and into residential aged care. Despite multiple reminders to providers to prepare for a potential COVID-19 outbreak, the review identified *inadequate administrative and environmental controls* and *staff training* in key aspects of IPC at both facilities prior to the outbreak. However, it is acknowledged that at the beginning of Victoria's second wave, the strict IPC precautions required to prevent transmission of COVID-19 in RACFs, were inadequately recognised by many providers;

Leadership and effective management are the most significant factors in preventing and controlling any emergency *but they faltered* at both St Basil's and Epping Gardens, in the context of COVID-19 outbreaks which were already established before effective responses were mounted. Notwithstanding this challenge, many people who worked in the RACFs or were involved in their multifaceted outbreak responses, faced situations they had never experienced before or for which they were (and/or felt) inadequately prepared. Their commitment and persistence helped eventually bring the situation under control but tragically, for some residents and

their loved ones, it was too late. Clinical governance was absent (at worst) or limited (at best);

Surge workforce planning at each of the facilities *was inadequate to manage the scale of the outbreak*. This was exacerbated by the growing demand for staff, across the aged and health care sectors, at that time. Managing the deployment of the general clinical and care workforces was an extraordinary combined effort on the part of the Commonwealth and Victorian health departments, in conjunction with workforce agencies and local health services. In turn, health services worked with private hospital providers in a new "hub" model in Victoria which deployed staff into the affected facilities. Staff were also recruited from interstate.

However, the sheer demand could not be matched with an adequate numbers of staff with aged care – or suitable alternative - experience. Clinical (nursing and medical) staff were augmented, as a result of close working relationships with Victorian public health services, most notably Austin Health and Northern Health, and several private hospitals. In addition, through local contacts, a number of key clinical leaders (some with aged care experience) were directly approached to provide consistent on-site clinical leadership whilst the respective outbreaks were brought under control;

Health department, interagency support and communications remain an *ongoing challenge* but the reviewers note *significant improvement and streamlining of communication*. For example, there are new processes in place since the reviews were undertaken in New South Wales which provide automatic triggers for provision of supplies such as surge workforce, PPE and pathology testing. From a provider's perspective however, there are still large numbers of key personnel engaged in interagency communications and for some providers, the sheer number of people, agencies and departments is confusing and intimidating. Providers also report multiple directives and requirements from daily meetings which are time-consuming and labour-intensive. The establishment of the Victorian Aged Care Response Centre has been a widely applauded initiative of the Commonwealth and Victorian governments, facilitating a 'one stop shop' approach to managing an emergency aged care event, bringing together all key players from an emergency, regulatory, public health, care delivery and advocacy perspective;

Pathology testing *was delayed* at both facilities. Whilst there were different drivers for this, the testing delays were ultimately the product of an exponential surge in demand for public health and laboratory services, and contributed to delayed cohorting of residents and potentially, to further spread of COVID-19 in the facilities;

Family and resident experiences were *largely unsatisfactory*, contributed to, most significantly, by issues related to communication and care delivery. Zoom meetings have been identified as welcome and timely circuit-breakers and provided an

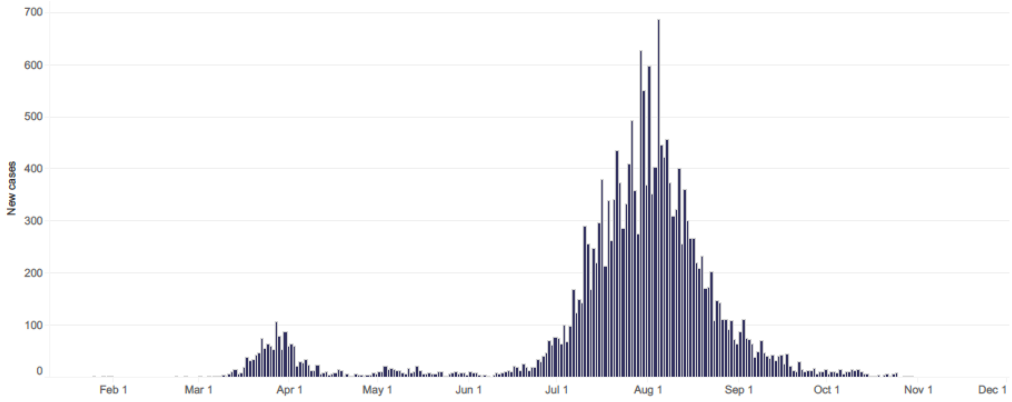
opportunity for face-to-face communication. However, what families desire most is regular, up-to-date information about their loved ones. In the absence of being able to see them directly or speak to a staff member who knows them well, concern and anxiety is elevated. Family members told reviewers that it was not uncommon for relatives to demand to see their loved ones or to take extraordinary steps, including seeking access through back-gardens, to catch a glimpse of them through a window. This review identified a pressing need to enhance opportunities for residents to meet with their loved ones in a controlled environment, with appropriate infection control precautions in place during the course of an outbreak.

In the past three months, systemic improvements have been implemented in the aged care sector in Victoria. They have been designed to strengthen resilience and support for RACFs, and minimise the scale and impacts of future outbreaks. This review of the settings, events, outcomes and lessons of two major outbreaks, will add to existing evidence to support preparedness and mitigate the effects of infectious disease outbreaks – including of COVID-19 - on elderly Australians, their families and carers.

The report discusses each of these key findings in further detail and provides insights into the challenges of managing a COVID-19 emergency. Using the *Swiss Cheese* model outlined earlier, the report further discusses the factors driving COVID-19 outbreaks and highlights the lessons learned which must be considered to inform future practice in residential aged care.

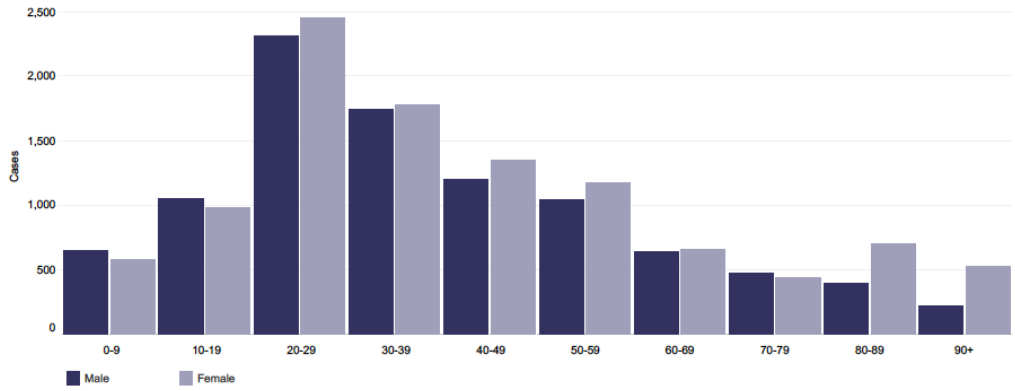
Background and Introduction

COVID-19 outbreaks in two residential aged care facilities (RACFs) in the northern suburbs of Melbourne - St Basil's and Epping Gardens - began in July 2020, when Victoria's second wave of COVID-19 community transmission was rapidly escalating. Sporadic COVID-19 cases had already occurred in RACFs in Melbourne and other large outbreaks would develop during July and August, but these were among the first of significant size. Outbreaks in RACFs generally follow trends in community transmission. This figure[3] illustrates the trajectory of the second wave of COVID-19 in Victoria.



Daily cases peaked at 687 on 4 August and total active cases at 6,767, on 7 August. At the time of writing, there have been no new cases in Victoria since 31 October.

The second figure[4] shows the distribution of new cases across age groups, split between males and females. Although *mortality* rates are highest in residential care as described above, *case* rates are highest among young and middle-aged adults aged 20 to 59 years.



[3] *https://www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data*
[4] *https://www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data*

The fact that COVID-19 could spread rapidly within RACFs and lead to preventable loss of life among vulnerable elderly residents was confirmed, as early as March 2020, by outbreaks in the northern hemisphere and in New South Wales. In Victoria, the numbers of cases among staff and residents in RACFs were highly variable but elderly residents were disproportionately represented among people who died from COVID-19. Of 907 deaths from COVID-19 in Australia, to 9 November, 685 (76%) were among residents of aged care facilities, predominantly in Victoria. This represents a 33% case fatality rate among 2049 aged care residents infected with COVID-19, compared with 10% (eight of 81) among recipients of home aged care[5].

High case attack and mortality rates in RACF outbreaks are not inevitable. To 6 November, there have been 222 COVID-19 outbreaks in 216 RACFs in Australia[6], all but five of which were in Victoria; 130 were limited to one or two cases and even larger outbreaks have been controlled with relatively fewer deaths among residents.

Emergency response planning, frameworks and resources have continued to evolve, since early 2020 at a Commonwealth, State and Territory level. During the recent outbreaks in Victoria, significant resources were provided and deployed by the Commonwealth and State governments to manage the unfolding emergency.

The reviewers noted ongoing improvements in the DoH's COVID-19 outbreak case management model and improved co-ordination with the distribution of PPE and scheduling of pathology testing. Similar improvements were also noted with respect to the availability and co-ordination of surge workforce.

These improvements were augmented by the formal establishment of the Victorian Aged Care Response Centre (VACRC) which played an integral role during the outbreak. Established in late July 2020, it brought together key personnel from:

- the Commonwealth DoH;
- the DHHS Victoria;
- Emergency Management Australia;
- Emergency Management Victoria;
- the ACQSC;
- the Australian Defence Force (ADF);
- Australian Medical Assistance Teams; and
- the Commissioner for Senior Victorians.

The VACRC was led by an executive team, supported by clinical and operational leads. In conjunction with medical, nursing, allied health, infection control and support staff, VACRC was established to provide a rapid and unified response to the escalating outbreaks. This commenced from notification and continued through to

[5] *https://www.health.gov.au/sites/default/files/documents/2020/11/coronavirus-covid-19-at-a-glance-9-november-2020_0.pdf*

[6] *https://www.health.gov.au/resources/publications/covid-19-outbreaks-in-australian-residential-aged-care-facilities-6-november-2020*

repatriation of residents. There have been many examples of collaboration and rapid learning, accompanied by a dynamic range of innovative approaches, roles and solutions.

Its work has been complemented by the DHHS establishment of a "hub model" which aligns all RACFs in Victoria to a health service hub, clustered on a geographic basis. The health service hubs are led by a nominated public health service and private hospitals are included. This work also progressed rapidly during the COVID-19 second wave and is now formally incorporated into the VACRC model. The role of metropolitan health service hubs was significant in the management of the outbreaks at the homes which are the subject of this review.

The Royal Commission into Aged Care Quality and Safety (the Royal Commission) also held a hearing in August 2020 as part of its investigation of the response to COVID-19 in aged care. Its Special Report[7] was delivered on 30 September and outlined six key recommendations. The first recommendation was that the Australian Government should report to Parliament by no later than 1 December 2020 on the implementation of these recommendations. In its Special Report, the Royal Commission concluded:

"The COVID-19 pandemic has been the greatest challenge Australia's aged care sector has faced. Those who have suffered the most have been the residents, their families and aged care staff. The suffering has not been confined to those homes which have experienced outbreaks. Thousands of residents in homes that have not suffered outbreaks have endured months of isolation which has had and continues to have a terrible effect on their physical, mental and emotional wellbeing."

A cautionary note on infection prevention and control (IPC)

The reviewers note that during 2020, the discussion about IPC increased exponentially, in line with the growing prevalence of COVID-19 globally. Consistent with increased public health messaging, expectations have also increased.

IPC advice must always be considered and practiced contextually. Staff working in operating theatres practice IPC differently to those working in a general ward, an aged care home or a mental health unit.

In early 2020, prior to the pandemic reaching significant proportions in Australia, there was a significant focus on IPC preparation in RACFs, driven largely by the ACQSC and the Commonwealth and jurisdictional health departments. A focus on hand hygiene was an example of this. Messaging about washing hands was prolific. Everyone was taking an increased interest in hand hygiene. It sounds so simple but hand hygiene practice is much simpler to discuss, than it is to do. This is best illustrated by the hand hygiene compliance data which is regularly collected in Australia, based on the '5 Moments of Hand Hygiene' (as defined by Hand Hygiene Australia).

[7] *https://agedcare.royalcommission.gov.au/publications/aged-care-and-covid-19-special-report*

In October 2019, the Australian Commission on Safety and Quality in Health Care (ACSQHC) published a National Hand Hygiene Initiative Manual[8] in which it reported data on improvements in national hand hygiene compliance from 2009 through to 2017. Hand hygiene compliance is usually assessed in relatively structured, disciplined acute hospital settings. In these settings, the improvement in rates, from an overall hand hygiene compliance rate of 63.6% in 2009 to 84.3% in 2017, is pleasing. However, a shortfall of 15.7% in correct hand hygiene moments remains between the 2017 rate and getting it right, every time. In terms of reducing healthcare associated infection rates, this is a significant gap and requires ongoing improvement and monitoring. Results for the second quarter of 2020 show that the average compliance rate has increased to 88.2%[9]

However, in context, this finding is instructive in understanding the complexities of IPC practices undertaken by individuals working in acute and sub-acute healthcare settings. Moreover, hand hygiene is only one aspect of IPC, the appropriate use of PPE has also been another major focus of the response to COVID-19. It therefore follows that improving IPC practices will be and is, much more challenging in environments outside of acute health care and in the context of this review, particularly in aged care. The improvement in hand hygiene compliance highlighted in the ACSQHC report took eight years to achieve, which firmly indicates that embedding even one aspect of an 'IPC mindset' is a longer journey than the one travelled to date though this COVID-19 pandemic.

Improving IPC is everyone's business. And it is the improvement which the reviewers propose needs to receive priority attention from everyone working in health and aged care and from those who fund service delivery.

The Review

This Independent Review was commissioned by the Commonwealth Department of Health to learn from the COVID-19 outbreaks at Epping Gardens and St Basil's. The reviews of each facility were conducted concurrently over a 10-week period during September to November 2020 and undertaken by Professor Lyn Gilbert AO and Adjunct Professor Alan Lilly. Their professional profiles are outlined in Appendix I. The review included site visits, an assessment of more than 400 documents provided to the review, 50 meetings which generated more than 125 hours of discussions and engagement with more than 100 participants, individually or in small groups and mainly online. People who provided information for these reviews included:

- residents and their family members who responded to invitations to participate;
- representatives of older persons advocacy organisations;
- facility managers, executives and senior management representatives;

[8] *https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-hand-hygiene-initiative-user-manual*

[9] *https://doi1e3eo0i66y.cloudfront.net/static-resources/national_report/2a0333e6-c411-4bd0-af78-00960ae3492b/index.html?dd8713e1*

- officials of Victorian and Commonwealth government departments and agencies including the ACQSC;
- surge workforce providers;
- advisers appointed to assist facilities, as required by the ACQSC;
- public and private hospital doctors and nurses involved in in-reach services and emergency responses; and
- representatives of health services and emergency services.

Residents and family members were also invited to make written submissions. A total of 15 written submissions were received, some of which were to support personal representation made in a series of 12 resident and family feedback meetings involving 46 residents and family members. A summary of all interview meetings is attached at Appendix II.

NB: As there is a coronial investigation into deaths at St Basil's, some residents and families consented to recordings of those interviews being shared with the review team, as an alternative to conducting additional meetings. These recorded interviews have been considered in this review.

Although these conversations recalled harrowing and often tragic experiences, the people involved were incredibly generous with their insights and time. Many were grateful for the opportunity to tell their stories, in the hope that they may contribute to prevention of similar tragedies in the future. Few relatives of residents who had died or been seriously affected by the outbreaks sought to apportion blame. However, many expressed their frustration about poor communication from providers or facility managers, during or since the outbreaks. Most of all, they were dismayed by the prolonged isolation and perceived neglect of their loved ones. Many of those most closely involved in managing these outbreaks, as facility managers or staff, agency staff, government officials or hospital clinicians, also expressed frustration and often, guilt, about their failure to prevent its worst consequences, despite their best efforts. The physical and emotional effects on some (from COVID, stress-related illness or exhaustion) was palpable, although few complained.

As the Royal Commission noted in its special report:

"Now is not the time for blame. There is too much at stake. We are left in no doubt that people, governments and government departments have worked tirelessly to avert, contain and respond to this human tragedy. However, the nation needs to know what lessons have been and can still be learnt. The nation needs to know what is being done, and what will be done, to protect those people receiving aged care services—those who this virus has affected disproportionately and whose entitlement to high quality care in safe environments that protect their wellbeing and dignity falls within the scope of our commission".

The reviewers agree. This report sets out to understand what occurred and importantly, what can be learned from the outbreaks at Epping Gardens and St Basil's.

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;
- leadership and governance during the outbreak;
- support from Commonwealth and State agencies;
- the outbreak experience for residents and families;
- lessons learned from the management of the outbreak.

Consideration of the following factors was 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;
- detailed financial matters relating to the outbreak;
- regulatory action of the Aged Care Quality and Safety Commission.

Limitations

In an independent review such as this, the reviewers have no coercive powers to compel engagement in the review process or compel the provision of documents. Such engagement and information-sharing is encouraged on a voluntary basis.

Legal proceedings are currently underway at both Epping Gardens and St Basil's. Legal advice has discouraged, limited or prevented the direct engagement and involvement of some officials, staff or family members in the process.

The Victorian State Coroner is investigating the deaths of residents at St Basil's and media has reported the launch of class actions and negligence claims against the owners of both Epping Gardens and St Basil's.

However, the review team has sought to work openly and co-operatively with all parties although in some cases, this has not improved access to information.

The COVID-19 outbreak at St Basil's

Introduction

St Basil's, Fawkner, is located in the northern suburbs of Melbourne, approximately 13 kilometres from the Central Business District. It was established as a hostel in 1996. A dementia-specific unit was added in 1998 and a nursing home section in 2005. It is currently registered for 150 places. St Basil's is owned and operated by the Greek Orthodox Archdiocese of Australia, which is registered as the Approved Provider within the meaning of the Aged Care Act 1997. The Chairman of the Board, at the time of the outbreak was Konstantin Kontis. The Chairman and Director of Nursing/Facility Manager (Manager) were the spokespersons for the Approved Provider during the COVID-19 outbreak.

The service was subject to a full site audit and review by the ACQSC in July 2019. It met all 42 requirements across eight Aged Care Quality Standards and achieved full accreditation until November 2022. The service achieved an overall *average agreement* score[10] of 92.4%, measured across ten domains, in a survey of quality of care and services completed by a number of residents and/or representatives, at the time of the site audit.

The facility has 147 single and three double rooms, with three shared bathrooms. It is divided into three main sections - hostel (54 beds); nursing home (72 beds); dementia unit (24 beds). In July 2020, when the COVID-19 outbreak began, St Basil's had 117 residents and approximately 120 staff members.

A high proportion of residents are of Greek or Serbian origin and many speak little, if any, English. Many staff are also Greek-speaking and the Greek-style food, activities and culture of the home were highly valued by residents.

Most residents and their families were generally happy with the care provided. Many relatives reported they had very good relationships with staff, some of whom had worked at St Basil's for many years. Staff numbers, including nurses (RNs), were generally considered to be appropriate. According to a local geriatrician, St Basil's was regarded as one of the best RACFs in the district.

Perhaps inevitably, not all were satisfied. Some relatives reported often having difficulty finding staff to provide information or assistance, especially at night and weekends.

[10] *https://www.agedcarequality.gov.au/sites/default/files/media/St%20Basil%27s%20Homes%20for%20the%20Aged%20in%20Victoria3150-7-cer.pdf*

Information for this Review

Most of the information about St Basil's on which this review was based, was provided by representatives of Victorian or Commonwealth government departments and agencies, other external agencies or residents' family members and advocates. There was limited information available from the Approved Provider, apart from documents provided by solicitors acting for them and publicly available correspondence. Many of the documents provided, were out-of-date or from external agencies. The Chairman and Manager were invited to participate in the review but declined based on legal advice. Responses to written questions were not received by the requested deadline. Whilst they were taken into consideration in the final report, they were considered to have added little new information.

The Outbreak

St Basil's outbreak preparedness

Based on responses to self-assessment surveys from the ACQSC and DHHS, St Basil's managers believed they were adequately prepared to manage a COVID-19 outbreak.

A document provided to reviewers, entitled 'Infection Control – Pandemic and Outbreak Management', April 2020, outlines procedures for control of selected infectious diseases outbreaks, including COVID-19. The reviewers did not consider this to be an adequate outbreak management plan (OMP). However, it was noted that a folder of reference documents, mostly from external agencies, was available for staff and this was used on a regular basis. It was noted that the document folder did not include more recent advice from the ACQSC (COVID-19 flow chart[11]) or the DoH (First 24 hours – Managing COVID-19 in a Residential Care Facility[12]).

In response to written questions, reviewers were informed that there is no designated outbreak management committee, other than the 'Continuous Improvement Committee' which reportedly fulfilled this purpose and has met monthly for years. It is chaired by the manager and members are senior nurses. The continuous improvement register was updated to include COVID-19, in March 2020. No information was provided about the role, if any, of this committee in response to a COVID-19 outbreak.

Reviewers were advised that St Basil's staff received COVID-19 training at monthly intervals from March to June 2020, during shift handovers. It was conducted by external doctors, whose IPC expertise is unknown, and based on a 2013 guideline

[11] *https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-flowchart_a3_posters_v12.pdf*
[12] *https://www.health.gov.au/sites/default/files/documents/2020/07/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility-first-24-hours-managing-covid-19-in-a-residential-aged-care-facility_1.pdf*

('Prevention and Control of Infection in Residential and Community Aged Care'), which would have little specific relevance to prevention and control of COVID-19. Training records consisted of a list of attendees' names and dates.

Daily PPE training for staff began on 9 July *after* the outbreak had commenced. Training records consisted of names handwritten on copies of a PPE poster from the Centers for Disease Control and Prevention (USA).

Phase 1 – the old regime: 8-21 July

On 9 July, the Manager phoned the PHU to report a case of COVID-19 in a staff member. She indicated that the staff member's close contacts at St Basil's had been identified and quarantined. As this was not a formal (laboratory) notification, information was provided about enhanced cleaning and contact tracing and the caller was instructed to await further contact. A laboratory-notification received by DHHS on 9 July, was referred to New South Wales Health[13] for contact tracing. The 'case' was interviewed on 11 July and identified as being a St Basil's staff member. This information was conveyed to the PHU, by email, the next day. The PHU immediately followed up with St Basil's by phone and email, with information about the definition of close contact and guidance on contact tracing and IPC measures. St Basil's provided a list of residents and staff, for contact tracing, and reported that residents were isolated and staff cohorted in one section of the facility.

The ACQSC became informally aware of the case, during a call to St Basil's for an unrelated survey, on 10 July. In response to a routine question, they were told that a staff member had received a positive COVID-19 test result on 8 July and the PHU was notified on 9 July. However, DoH did not become aware of the case until 14 July, when it was mentioned by a PHU officer, at the daily aged care case management meeting (attended by representatives of DHHS, ACQSC and DoH). Meanwhile, many staff members had sought testing externally and the PHU had been notified of three St Basil's staff with COVID-19. Eleven staff and 16 (of 117) residents were identified as close contacts and quarantined. A case manager and case lead were appointed, from the DoH Victorian office, Aspen Medical[14] was alerted to send a clinical first responder (CFR) to St Basil's and testing of all residents and staff was requested.

On 15 July, 213 residents and staff were tested, by Melbourne Pathology[15], and a DHHS IPC Outreach Nurses (IPCON) squad visited St Basil's to assess the facility layout and IPC practices. The squad noted a need for improved access to hand sanitiser and personal protective equipment (PPE), leadership to ensure their correct

[13] *Because of the large number of cases in Victoria at the time, other jurisdictions were assisting with contact tracing*

[14] *Aspen Medical was contracted by the Commonwealth to provide a key role in Australia's COVID-19 outbreak response, including in provision of surge workforces for RACFs whose own staff numbers were depleted by illness, quarantine or absenteeism for other reasons. CFRs are senior clinicians with management experience who can provide a link between the facility and DoH case manager.*

[15] *Melbourne Pathology is a Sonic Healthcare laboratory, contracted by the DoH to provide COVID-19 diagnostic testing for RACFs nationally.*

use and IPC education at each staff handover. They recommended separation of PPE donning and doffing stations, replacement of vinyl with nitrile gloves, emptying of waste bins twice daily and additional signage. On 16 July, an Aspen CFR met with the Manager and a senior nurse. She noted that staff were wearing PPE, with no obvious breaches and, apart from a few 'wanderers', residents were in their rooms, with the doors closed. Follow-up offers of assistance, over the next few days, were declined.

A new case lead, who was appointed on 17 July, was alarmed by the number of COVID-19 cases identified at St Basil's in the first round of testing - 25 (13 staff, 12 residents), with further results pending. He convened an urgent operational meeting on Saturday 18 July. However, the St Basil's representative reassured him that the facility was in lockdown, COVID-19 cases were confined to one section of the facility, PPE supplies and staff numbers were adequate, and Northern Health residential in-reach (RiR) team was providing clinical support. Final results of the tests collected on 15 July gave the total case numbers, less than a week after the index case, as 33 (15 staff, 18 residents).

By then, there were other signs that the situation was less well-controlled than it appeared. For example, a senior Ambulance Victoria officer and several residents' families told reviewers that a number of 000 calls from St Basil's had been made, including three on one day, requesting urgent transfers of residents to hospital on the advice of a local doctor. Some of these residents were asymptomatic or assessed as not requiring admission and sent back to St Basil's, which was distressing for them and their relatives. This seems to suggest that there were different expectations or poor communications between St Basil's and DHHS/hospital authorities about the indications for hospital admission of residents with COVID-19. An RiR geriatrician, who visited St Basil's on 18 July, told reviewers that, in his view, St Basil's did not have adequate supplies of PPE and its use was inconsistent. He noted that COVID-19-positive residents were no longer confined to one section of the facility.

Public Health action

At operational meetings, on July 19, 20 and 21, St Basil's representatives were asked for more detailed information about residents' clinical status, staffing and PPE supplies. Several participants at these meetings told reviewers, independently, that St Basil's responses were incomplete, although they remained confident that staff numbers were adequate. However, information about staff and residents who had tested positive was subsequently provided to ACQSC and DHHS and it was confirmed that close contacts had been furloughed. Nevertheless, DHHS was not satisfied that it had adequate information to be confident that all close contacts had been identified. Meanwhile, case numbers had increased to 65 (47 residents; 18 staff), after a second round of testing on 19 July.

In view of escalating case numbers and uncertainty about who were close contacts - and therefore potentially infectious - the PHU deemed that all staff who had been in clinical areas at St Basil's for two hours or more, cumulatively, between 1 and 15 July, would be designated as close contacts and required to self-quarantine for 14 days. This decision was first conveyed to St Basil's on 20 July. As this definition applied to all staff, the Chairman expressed grave concerns about the effect of a stand down, on resident care. His concern was shared by the RiR geriatricians, who believed that, despite some difficulties, good basic care was being delivered at St Basil's. They feared there would be serious consequences if all staff were furloughed. The ACQS Commissioner also supported a more nuanced response.

DHHS conceded that full stand down would be challenging and could be delayed for two days until a suitable surge workforce was found but insisted it was necessary for the safety of residents. The Chairman stated that he would not comply without an explicit order. However, he later offered that, in the event of stand down, senior staff could be quarantined in separate on-site independent living units to support replacement staff. This offer was made in a conversation with the ACQSC on 21 July and repeated at an operational meeting later the same day.

On the evening of July 21, a letter confirming the public health order was sent from the Victorian Chief Health Officer to the St Basil's Chairman. It stated that staff who fulfilled the definition of close contact must leave the facility, by close of business on 22 July, and remain in home quarantine for 14 days. Handover to the surge workforce could occur, to maintain service continuity, so long as any St Basil's staff in attendance were asymptomatic, wore full PPE, maintained physical distancing and remained in the facility for the shortest possible time. The Approved Provider was asked to provide names, dates of birth and contact details of all staff for contact tracing.

The Chairman's response, published on the St Basil's website[16] the next day, reflected his frustration:

"*We note that our entire leadership and management team will be completely sidelined so it cannot be said that we are in control or managing the facility during this period as we will not have any supervisory or oversight input whatsoever for the duration of the period during which our staff are in mandatory isolation. For the record, we reiterate our concern that we have no confidence that the replacement staff are not also infected with COVID-19 or may become infected by COVID-19 by community transmission given all of these people are coming from the same pool of workers who have either been working in other facilities or have other risk factors inherent to this pool of workers. Furthermore, we do not know who any of these replacement staff are and whether they are competent or trustworthy to provide care to our residents. The agency which was suggested by DHHS operatives appears to be a labour hire firm which takes no responsibility whatsoever for the actions of*

[16] *https://stbasilsvic.com.au/wp-content/uploads/2020/07/STB-TO-DHHS-Letter-22-JULY-2020.pdf*

the staff they provide. We further have no way of knowing whether there will be adequate supervision by the government appointed managers of the replacement staff and whether those managers have the capabilities and experience to manage a facility of this type".

Finding a suitable workforce

While negotiations between St Basil's, DHHS and ACQSC were occurring, the DoH surge workforce co-ordinator in Canberra, had begun working with Aspen to identify replacements for all St Basil's staff, to commence on 22 July. A small team from a culturally-specific aged care provider was recruited to provide on-site management support. Like St Basil's, they provided aged care for a predominantly Greek-speaking clientele, and had been identified, strategically, as a suitable source of support for St Basil's. Two senior staff volunteered; they were a facility manager, who had held several senior management roles and spoke Greek and a clinical care manager, who was a registered nurse also with management experience.

With less than 24 hours' notice, the replacement managers arrived at St Basil's at 7 am on 22 July, along with a large number of agency staff and the Aspen team[17], comprising three CFRs and several registered nurses (RNs) recruited from interstate. The Commonwealth Chief Nursing and Midwifery Officer (CNMO) and a DHHS Deputy Secretary were also there to observe the handover.

Comment

Several apparently minor errors occurred, which together were significant contributors to the St Basil's staff being stood down and the events that followed. The Manager notified DHHS when she was told of the index case but did not notify DoH. This meant that the request for testing of residents and staff, by DoH, was significantly delayed. COVID-19 outbreak guidance issued by the ACQSC on June 15[18] and by DoH on 29 June[19], indicated that the Approved Provider must notify a case of COVID-19 in a RACF by email to agedcareCOVIDcases@health.gov.au as well as to the local PHU. There were other missed opportunities when DHHS and ACQSC, both of which became aware of the index case independently, did not pass on the information to DoH. Unfortunately, this meant that by the time the first test results were known, the outbreak had already spread within the home and continued to do so, despite IPC practices that had been judged to be acceptable, albeit requiring some remedial actions, according to the IPCON squad.

Controversy and relatives' concern about the delay in testing were aggravated, when it was reported in the media that a bag of specimens was left overnight at St Basil's

[17] *Aspen CFRs often take a small team, which can be expanded, if needed, from their own extensive pool of credentialed, casual staff, including many with aged care experience. They are also expected to assist with staff recruitment, including personal care, nurses, medical, allied health and support staff, from other agencies.*

[18] *https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-flowchart_a3_posters_v11.pdf*

[19] *A fact sheet dated June 29 2020, from DoH, https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-facility*

before being collected by a taxi. Melbourne Pathology Medical Director explained to reviewers that a courier had failed to collect them because of a misunderstanding. She indicated that the specimens were securely packaged in sealed containers and did not pose a safety risk. They were processed within an acceptable timeframe. However, in future, a pathology collector would stay with the specimens until they were collected to avoid repetition of such an event, which caused public concern.

It was seven-ten days before the extent of spread was recognised and interventions by external authorities escalated. At the time, the pressure on all agencies was extreme, with increasing community transmission of COVID-19. There were daily counts in excess of 500 cases per day and active cases or outbreaks in more than 50 RACFs, in Victoria, of which St Basil's was one of the first. Government strategies to support RACFs were predicated on the Approved Provider activating their own outbreak management plan, including their own surge workforce, and maintaining command and control of facilities. When it was clear that the support needed at St Basil's had been underestimated, strategies to recruit agency staff, especially of workers with aged care experience, would prove inadequate to meet the demand.

Phase 2 - stand down and replacement of staff: 22-24 July

Accounts of what happened on the morning of 22 July, and over the next ten days, are confused and sometimes contradictory. 'Chaotic' was a word used repeatedly by participants in this review, to describe the situation at St Basil's. When they arrived, it was some time before the new workers and managers were admitted. The new managers rapidly set about organising the staff, who crowded into the small foyer without physical distancing. The new managers started directing staff to don PPE, have their temperatures checked and separate into occupational groups. The plan was that agency staff would be paired with equivalent St Basil's staff - who were already on-site – for a 'buddy'/handover shift. They were not ready to start until after 8:00 am, leaving less than three hours, before St Basil's staff were due to leave the floor.

There was very little time for adequate handover of information for either resident care or adequate day-to-day functioning of the home. Both the incoming management team and Aspen CFRs reported that resident records were incomplete.

St Basil's staff were understandably upset; some told the new manager they did not know they were to be stood down. At 11:00 am staff were told to stop work and meet in the dining room, for a debriefing with management. Many were reluctant to leave the floor and some became hostile towards the new managers. St Basil's staff left the facility at about 1:00 pm.

The CNMO and Deputy Secretary attended the handover meeting between the St Basil's and replacement managers. The St Basil's manager and senior nurses were

reportedly very distressed at being forced to leave residents in the care of staff who did not understand their needs or the home's systems and routines. However, they agreed to provide whatever immediate assistance was needed and ongoing support. The CNMO and the Deputy Secretary both told reviewers that, when they left that afternoon, they were confident there were adequate replacement staff and managers in place and an orderly handover was underway. However, appearances proved to be deceptive.

The new managers told reviewers that the St Basil's manager later said she was not to be contacted, once she had left the facility and that, since they had been stood down, neither she nor St Basil's staff were to have any ongoing involvement. She subsequently partly relented and indicated that she could be contacted by email, once a day, if necessary, but only about non-clinical matters.

The new managers were understandably confused. They believed that the Approved Provider was legally responsible for the facility and senior staff would remain in contact and provide whatever information and advice was needed by the replacement management team whose role was to *support - not replace* – St Basil's management. Instead it seemed they could not rely on ongoing guidance from the Approved Provider as originally suggested by the Chairman. It was not clear how this misunderstanding arose or why it was decided that the St Basil's manager and staff were to have no ongoing involvement after they left. The reviewers' attempts to clarify this, by direct contact with the Chairman or Manager, were unsuccessful. Responses to written questions confirmed that some responses to specific requests for information were sent. However, the replacement managers reported that their calls and emails were often unanswered and they felt unsupported by St Basil's management.

In the event, none of the senior staff self-quarantined in the on-site units, as the Chairman had suggested. The reason given subsequently, was that the letter from the Chief Health Officer had specified that all staff were required to 'quarantine at home'. This was interpreted as implying that quarantine in the on-site units would not be acceptable to DHHS but it is not clear whether this option was discussed with them.

One of the Aspen CFRs who went to St Basil's on 22 July, reported how shocked she was by the situation. After St Basil's staff left the floor at 11:00 am, many residents were still in bed and their breakfast trays untouched. Many of the surge workforce had never worked in aged care and were unsure what to do. A shift changeover at 2:00 pm meant that a new staff cohort had to be orientated, screened and allocated roles. Like the managers, Aspen CFRs expected to be *assisting* St Basil's management with staff rosters, orientation and IPC training, at least on the first day, but instead they were left to supervise a disorganised and inexperienced workforce. For the rest

of that week, they spent 16-18 hours a day 'putting out spot fires' and struggling to maintain basic care of residents.

A difficult challenge for replacement managers and staff

The immense challenges that arose, during the three days after the stand down of St Basil's staff, was predicted by those who opposed it. The challenges were intensified by the nature of the resident population, many of whom spoke little or no English and could not communicate with agency staff. This problem could have been mitigated by guidance from St Basil's staff, who were familiar with residents' needs, had they been available, off-site, to facilitate communication between replacement staff, residents and their relatives.

By 24 July, COVID-19 had spread to at least 48 residents, of whom nine were in hospital and seven had died; many more were already, or would soon, be infected. The challenge, at that stage of the outbreak, was to ensure that all residents received appropriate basic care and medical attention. Participants in the review identified the many barriers to meeting the challenges including:

- *Staffing:* numbers and proportions of agency staff in different categories (personal care assistants [PCAs], RNs, enrolled nurse [ENs]), who were rostered in the first days after the stand down, were based on 'normal' rosters provided by St Basil's. The numbers varied from day to day and were inadequate, considering that:
    - residents were supposed to be isolated in their rooms and many were ill and needed far more 'hands-on' care than usual;
    - many agency staff had not worked in aged care and were unfamiliar with how to perform routine tasks, such as feeding, lifting, attending to toileting needs, bathing or showering of elderly, often incapacitated residents;
    - many RNs and ENs were very recently qualified and also inexperienced in aged care. They were often unable to perform routine nursing duties without supervision, let alone supervise inexperienced PCAs;
    - there were too few senior RNs to provide team leadership and supervision as well as nursing care;
    - English was the second language for many staff in all categories and a significant proportion spoke and understood it poorly;
    - managers, Aspen CFRs and agency staff from as many as 22 agencies, did not know each other or their roles, which made teambuilding difficult;
    - many staff found the situation highly distressing and did not return for subsequent shifts; variable numbers and high turnover meant poor care.
- *Infection prevention and control*: many participants in this review observed major breaches of IPC practice, and improper distribution, use and disposal of PPE:

- many of the surge workforce seemingly had limited understanding or previous training in IPC, especially in the context of a highly infectious disease outbreak;
- a DHHS IPCON squad went to St Basil's several times to provide guidance about signage, zoning and positioning of clean PPE supplies and waste bins, but in the circumstances were unable to provide more than *ad hoc* training;
- staff often crowded into communal areas, without PPE or physical distancing, despite repeated reminders;
- the physical layout and increasing case numbers made cohorting of residents and staff, into COVID-19 positive and negative zones, difficult. Some residents were 'wanderers' and staff were often uncertain which, if any, were infectious;
- corridors were often cluttered, with piles of clean PPE and waste bins, often overflowing with used PPE.

- *Language and culture:* Most residents spoke Greek, and only a minority spoke good English; the acting manager was the only Greek-speaking staff member:
  - there were several other language groups and, initially, no interpreters;
  - residents were distressed and endangered by their inability to communicate their needs to staff;
  - for elderly residents used to traditional Greek food, poorly presented processed/packaged (often cold) food was unpalatable or inedible, even if they could feed themselves.
- *Residents' records*: Residents' photographs and handwritten clinical records, care plans and medication sheets, were kept in folders in the office:
  - staff often could not identify residents from their photographs, residents did not have identifying wrist bands and some had been moved to different rooms. Names on belongings in the rooms were sometimes not those of current occupants;
  - difficulty accessing or deciphering clinical records and identifying residents meant that medications and dietary requirements were often in doubt, administered inappropriately or missed.
- *Access to equipment, services and supplies*: Equipment often could not be located or used, or supplies and services accessed, without critical information, such as:
  - passcodes for the computer system, electronic records and photocopier;
  - location of keys to medication and stores cupboards or residents' rooms;
  - how to open external gates remotely to allow funeral directors in, at night;
  - contact details for food and catering suppliers or external service providers that were in inaccessible electronic systems;

St Basil's advised that a handover folder containing this information was left for replacement managers. If so, the new managers clearly overlooked it in the confusion of the first few difficult days and were not directed to it by the St Basil's manager, in response to specific requests for information.

- *Reporting to government*: At daily teleconferences, there were frequent requests from government agencies/departments, or *ad hoc* queries from ministers' offices for detailed information about residents' clinical status, test results etc.
    - there was no administrative or support staff to collect data manually or compile detailed reports;
    - it was frequently not clear who made the requests, as teleconference participants often did not identify themselves or their departments;
    - the same information, in different formats, was often requested by multiple agencies.
- *Media attention and political concerns.* Unable to get information or answers about their loved ones, increasingly anxious relatives resorted to contacting media and members of parliament, to draw attention to their concerns:
    - alarming media reports contributed to agency staff not wanting to work at St Basil's or returning for repeated shifts. They exacerbated relatives' fears and political pressure, leading to a vicious cycle of blame and fear.

Escalating concerns of senior nurses and external providers

It rapidly became clear that the hasty transition to a replacement management team and surge workforce was not sustainable, without more effective co-operation and day-to-day involvement of the Approved Provider. Many informants praised the efforts of replacement managers and Aspen CFRs but the challenges were beyond the capacity of such a small group of leaders despite their skills and experience. Soon after the stand down of St Basil's staff, concerns about rapidly deteriorating conditions were raised by some external providers, including: Aspen National Clinical Manager to Aspen senior management (July 22); a Northern Health RiR geriatrician to DHHS Deputy Secretary (July 24); Melbourne Pathology Medical Director, to DoH Secretary (July 24). Specific concerns included:

- residents not receiving meals until late and meal trays left untouched for hours;
- residents' often not washed or showered, and sometimes left in soiled beds;
- blood glucose levels not being checked regularly;
- medications not given or given inappropriately
    - e.g. insulin given to a resident who had not had not eaten for hours, leading to severe hypoglycemia, requiring urgent hospital transfer;
- residents left without water and becoming dehydrated; subcutaneous fluids prescribed by medical staff not given or allowed to run dry;
- PCAs unable to access or use hoists, leading to falls;

- numerous breaches of IPC practices; inadequate cleaning;
- uncertain identity of some residents leading to medication errors and delays in laboratory testing.

A third round of diagnostic testing scheduled for 23 July could not be completed because the identity of some residents - or whether they had previously tested positive - could not be confirmed (it was policy not to retest people who had already tested positive). The situation was not resolved by the next day. The Patient Services Manager, herself a trained nurse, was so distressed by the disorganisation and condition of residents that Melbourne Pathology refused to allow collectors to return until their concerns had been addressed.

Results of the tests that were completed on 23/24 July, revealed a further increase, in cases among residents, to 70. Ten of these COVID-19 positive residents had died and many needed hospital care. Rather than relying on *ad hoc* emergency 000 calls, a plan was developed for elective transfers of the most vulnerable residents to reduce the workload and unrelenting spread of COVID-19.

Throughout the three long weeks of the COVID-19 outbreak at St Basil's, countless individuals worked tirelessly and with great sacrifice to contain it. There were innumerable acts of caring and compassion. Despite their efforts, many of the challenges they faced could not be met, without decisive action.

Comment

The decision to stand down 100% of St Basil's staff was consistent with public health requirements at the time and based on assessment of unacceptable risk to residents of further exposure. Its success was predicated on appropriate handover to a replacement workforce. Presumably, to achieve transfer of care of a large resident population, this would imply full *cooperation* from the team handing over, adequate *time* and *documentation* and a *suitable replacement workforce* to hand over to. In the event, none of these was available.

In retrospect, allowing a select group of St Basil's staff to stay (uninfected wearing appropriate PPE and with strict conditions attached) may have averted the worst outcome but this was not consistent with public health policy at that time. However, this position is consistent with feedback to the review from St Basil's.

After the St Basil's experience, the public health directions in Victoria were modified so that the Chief Health Officer can grant an exemption, on the advice of VACRC, which would allow close contacts, who may become infectious, to continue to work, under certain conditions, to maintain the quality of care.

Phase 3 - staged transfers and Notice to Agree: 24-27 July

The seriousness of external stakeholders' concerns and mounting pressure from relatives and the media, highlighted the need for more experienced nursing care on site and strategic hospital transfers of the most vulnerable residents. Based on existing contracts between DoH and private hospitals, DHHS arranged for several of them to accept St Basil's residents and provide additional nursing support.

On 24 July, an Ambulance Victoria Incident Commander and Field Emergency Medical Officer (FEMO) arrived early at St Basil's, to coordinate transfers. The list of transfers had only just been finalised and St Basil's staff had not had time to prepare. Identifying residents, finding personal belongings, and copying records and medication sheets with only one printer, were very time-consuming. The FEMO assessed priorities for immediate transfer and assisted with obtaining relatives' consent. Long delays meant that completing the daily allocation of transfers would continue into the evening, with increased risks to residents and distress for relatives, many of whom were gathered outside hoping to catch a glimpse of their loved one as they left.

That evening, a team of senior nurses, the Chief Medical Officer (CMO) and IPC Director from Epworth Hospital went to St Basil's to assist with immediate transfer of residents allocated to Epworth. Like many others, the CMO was shocked by the confusion, obvious IPC breaches and the condition of residents, some of whom were wandering in the corridors, obviously distressed. *"I've never seen anything as appalling as this in Australia … in terms of health care provided to Australians."*

After clinical assessment, the CMO decided that only five of the 10 'high priority' residents required urgent transfer that evening. The other five were transferred next morning. Over the next two days, many more residents were transferred to Epworth (Richmond), Peninsula Private Hospital (Frankston) and other private hospitals, leaving less than one third of the original 117 residents remaining at St Basil's.

Comment

Hospital transfers of elderly residents are associated with inherent risks to residents, extra work for staff and distress to families. The risks are exacerbated if transfers are unnecessarily hurried or take place after-hours, especially if they involve patients with a highly infectious disease. Patients' arrivals at the receiving hospital, need to be preplanned so that patients can be moved through the building without risk to other staff or patients. At Epworth, patients were taken to the ward via a basement entrance and a dedicated lift, which was cleaned before reuse.

Many elderly residents became distressed and confused during and after transfer and exhibited what has been termed 'aerosol-generating behaviours' – crying, calling

out, singing – which increases infection risk to staff. Enhanced IPC measures, including extra IPC training and appointment of PPE 'spotters' to ensure correct use, had been implemented, at Epworth in anticipation of receiving COVID-19 patients.

On 26 July, Epworth Associate Director of Clinical Services (ADCS) went to St Basil's, to support nurses, distressed by conditions there. She remained to assist with ongoing resident care and transfers. The CNMO returned to St Basil's the same day and reported that ambulances were lined up in the driveway and groups of relatives and media teams gathered outside. The situation inside remained chaotic.

Also on 26 July, the ACQSC, as national regulator, issued St Basils' with a Notice to Agree[20], based on the "*…concerns about the serious impact of the outbreak on the residents and staff, and the response of the approved provider"* including *"…ongoing challenges apparent in implementing an effective outbreak response in a timely manner, and in fulfilling responsibilities to provide timely communication relating to the care of individual residents"*. This meant, *inter alia,* that the provider must *"…appoint an independent adviser to ensure the health and well-being of residents."*

Under new management: July 27-31

Additional management support was needed, not only because of ongoing risks to residents but also because the replacement managers were exhausted and had indicated their intention to leave on 29 July, once the planned hospital transfers were completed. On 27 July, a new facility manager with extensive healthcare management experience arrived and the Epworth ADCS took over as clinical manager allowing a two-day management handover; the adviser also commenced in his role.

By then there were additional nursing teams from several hospitals. Agency staff numbers were adequate, but there was still a high turnover and problems of inexperience and poor IPC practice. In an attempt to improve workflow, several simple efficiency measures were introduced. Staff were asked to display their names and coloured stickers to indicate their roles (RN, EN, PCA etc.) on face shields and wrist bands were placed on all residents. Another printer was purchased.

The clinical manager initiated a new routine with a morning handover/'huddle' and hourly rounds to ensure that each resident was seen, given food and water, helped out of bed, dressed and washed. However, residents' care remained unsatisfactory, even though fewer residents remained in the home.

The lack of access to information about suppliers and service providers also remained an ongoing and time-consuming issue. Food was often not delivered and essential equipment could not be ordered because of problems with the ordering system. The new manager reported that the washing machine broke down and no-

[20] *https://www.agedcarequality.gov.au/media/88180*

one would come to repair it, so residents' clothes could not be washed; then an oven broke down. These issues were raised at daily meetings attended by the Approved Provider, ACQSC Compliance Director, facility manager and nurse advisor. Participants who attended these meetings described them as tense and argumentative. The Approved Provider appeared unwilling or unable to take responsibility for assisting with these operational issues and they remained unresolved to the new manager's satisfaction.

On a positive note, the Melbourne Pathology Patient Services Manager returned with collectors for another round of testing on 28 July and was impressed by major improvements, including that collectors could now identify all residents and the facility was spotless, after a visit by contract cleaners.

The results of that day's tests proved to be problematic. Some staff received their results by SMS the next day, but others had not received theirs three days later. After the new facility manager was given access to the Melbourne Pathology portal, she discovered that several staff who had tested positive were still rostered to work. Apparently results had been sent, appropriately, to the general practitioner who authorised testing, but not passed on to the staff member or rostering agency and laboratory notifications to DHHS apparently were not flagged as being from St Basil's staff members.

By July 31, it was clear that, despite an experienced new leadership team, the well-documented chaos was unresolved. The remaining COVID-19 negative residents were still at risk of infection and overall care of residents remained inadequate. The Epworth ADCS was due to return to Epworth that day, with no replacement identified for her at St Basil's and despite requests for senior staff with aged care experience, none had been found. Therefore, the on-site management team suggested and DoH officials agreed, that all remaining residents should be evacuated.

It is a credit to the clinical manager, ambulance crew and receiving hospitals that, despite the continuing challenges and short notice, all remaining residents were transferred to various hospitals, in one day.

Experiences and Reflections of Relatives

Reviewers contacted St Basil's residents and their representatives, inviting them to meet in small groups, via videoconference or provide written submissions to share their experiences. Three group videoconferences were conducted, each with four or five family representatives (14 families, 16 individuals), and five individual telephone or videoconferences. Written submissions were received from nine families along with recordings of interviews with five residents

Most of the residents and relatives who participated were of Greek origin, or from Serbian or similar backgrounds. Many of the residents spoke and/or read little or no English and they (or their relatives) had chosen St Basil's because of its strong Greek culture, food, activities and roots in the Greek Orthodox Church. Residents could attend mass each week and a priest visited regularly. With few exceptions, they were pleased with the level of care and ambience of the home. As part of the local Greek community, they often continued existing friendships or formed new ones at St Basil's. Staff were described as caring and friendly and some had been there for many years. Most of the relatives, reviewers spoke to, visited frequently and knew the staff well.

A few relatives had complaints, some of which minor and/or infrequent, but a few more serious. One family complained that their mother was often not ready, when they arrived to collect her for a regular Sunday home visit; another that their bedbound mother sometimes had no drinking water in her room. One resident, who spoke no English, was apparently heavily sedated at night because she called out, although her daughter explained that she only did so when she needed assistance and her call button was not answered. One woman mentioned that staff were unhelpful when asked to look for her mother's glasses, which the daughter found easily on her next visit, in a chair regularly used by her mother.

St Basil's during the first COVID-19 wave, before the outbreak

Visitors were restricted, then excluded from St Basil's in March 2020 during the first wave of COVID-19 infection in Victoria. While this decision was understood and supported by residents and their families, many complained that it continued much longer than in most other RACFs, although relatives were told it was because of a government order. Some relatives questioned the fact that staff could come in and out of the facility, without wearing PPE, whereas relatives could not. One respondent was particularly annoyed that a staff member refused to deliver a piece of freshly cooked fish, which his mother had specifically requested. Some respondents believed that their loved ones' physical and mental deterioration began during this long period without physical contact with families, despite frequent video contact via Facetime or Skype. For residents who could not manage alone, this was facilitated by St Basil's staff but, even then, it was often difficult because of the effects of dementia or hearing loss.

In mid-May, St Basil's set up two visiting rooms in different parts of the home for 'contactless' visits. They were converted residents' rooms/spaces with a window between them, where residents could see and speak with relatives, by appointment. Most relatives appreciated this, despite its limitations. Others found it unsatisfactory and confusing for residents with dementia. It also placed an additional burden on staff.

Relatives were told that staff were much busier than usual during the lockdown, even before the St Basil's outbreak. Normally, ambulant residents could move about the facility or in the large grounds, go to the dining room and socialise independently. Many who were not mobile had frequent – sometimes daily – visits from relatives, and provided care and support, which staff relied on. Apart from increasing staff workload, enforced isolation led to cognitive decline and deconditioning, from lack of stimulation and exercise, for many residents.

One relative questioned why some family visits could not continue.

[Before the lockdown] *"… my father was sitting by her side from 7.30 in the morning till 6 o'clock at night. He would sit with her, feed her, and participate in the activities that were going on within the facility, … they had him on the Volunteers' Register, because he spent so much time there. That added value to his existence being there for so long".* His son had no doubt his father would comply with IPC precautions if he had been allowed to visit and both parents missed the visits terribly.

There was only a brief period between 26 June and 9 July, when visiting was allowed, before the outbreak began and the facility locked down again.

St Basil's during the outbreak

Relatives were notified of the outbreak in a letter from the Manager, dated 10 July and sent by email on 12 July. Some had heard of the staff member being infected before this and tried, often unsuccessfully, to contact St Basil's for information. Others said they did not receive the email or any other communication from St Basil's until later. One relative reported that a dental technician kept an appointment with her mother at St Basil's, on 11 July. The technician was not told of the outbreak and said that staff were not wearing masks. When asked about this later, the manager said that no-one who came during that time had symptoms and only the section where the infected staff member had been working was in lockdown.

There were mixed reports about communications with St Basil's, between 12 and 21 July. Most relatives had difficulty getting through but, if they did, they were told the situation was under control, DHHS staff had visited, deep cleaning was underway, and testing had been arranged. The manager wrote to relatives again on 15 and 17 July, about the increasing numbers of cases, but assured them that everything possible was being done. Many relatives were concerned that testing had not occurred before 15 July and subsequently had difficulty finding out the results.

Families became increasingly worried about rumours of residents in different wings being affected, residents dying from COVID-19, and some being sent to hospital and then back to St Basil's. In the weeks after the outbreak began, several families made

plans to take their loved ones out of St Basil's and care for them at home. A few managed to do so and were thankful they had, despite the difficulties.

Many relatives heard about the stand down from distressed staff members. One relative said a senior nurse told her: *"I can't guarantee the care of your mother if I'm not here. To replace everyone is going to be bad and …we, the doctors, the carers, the management of St Basil's have said …that if you replace us with surge workforce people are going to die of neglect not COVID".*

Details of what happened after that are varied, but consistently reflect the extreme distress and suffering of families and their loved ones, of whom so many died. Everyone mentioned their frustration in not being able to contact St Basil's. After 22 July, those who were able to maintain contact with their loved one by phone or video described becoming increasingly alarmed by what they were told or saw of their deteriorating physical or mental condition. Many residents complained about late meals or being unable to eat what was offered. Relatives were particularly concerned about residents' rapid weight loss, apparent dehydration and/or confusion.

When they managed to get through to St Basil's they often encountered staff whose English was difficult to understand and were sometimes unsympathetic or insensitive. On the other hand, some relatives received calls from staff at the home, to report test results or their concern about a resident's condition. Often the caller also spoke of their own distress and feeling of helplessness. Many other relatives had difficulty finding out test results and sometimes they were given a result, only to be told later that prior advice was incorrect.

Some relatives saw a scenario unfolding at St Basil's, similar to that at Newmarch House in Sydney, and were angry that lessons had not been learnt: *"….did we learn anything from the Newmarch in Sydney? I don't think so… And so we were just literally going from a mistake to a bigger mistake".* The reviewers note that the Independent Review of the Newmarch House outbreak had not yet been published.

As they became increasingly fearful for their loved ones' safety and frustrated at the lack of answers, many families contacted the media, the ACQSC, members of parliament or the Minister's office. As the first of the planned hospital transfers were underway, on 24 July, the first of several family webinars was held, attended by about 20 relatives, Minister Colbeck (Minister for Aged Care and Senior Australians), the ACQS Commissioner, DoH Secretary and DHHS Deputy Secretary who explained what was planned and listened to families' concerns.

When relatives were contacted to give consent for their loved one to be transferred to hospital most were relieved, but the information they were given was sometimes incorrect - the hospital to which the resident was sent was sometimes not the one the relative had been told, or the resident had already been transferred or would

not go until the next day. A number of residents arrived in hospital without essential belongings, such as dentures or reading glasses.

Transfer to hospital

Nevertheless, most relatives spoke highly of the hospital staff and the care provided. Staff phoned them when the resident arrived and frequently throughout their loved one's stay, sometimes daily or whenever their condition changed. Some were able to visit with full PPE, although usually this was only when their loved one was thought to be close to death. Many relatives said hospital staff told them their loved one was malnourished and dehydrated on arrival, sometimes with pressure sores; many were semiconscious, distressed and agitated or very ill with COVID-19. Some died soon afterwards, but generally relatives felt that everything possible had been done to care for them. Others rallied dramatically after transfer.

One relative whose father had COVID-19, rang the hospital the day after his transfer:

"*I asked 'Did my father eat?' And they said, 'Oh, yes... he ate a full bowl of porridge, three quarters of a plate of scrambled eggs and baked beans'. I said, 'My goodness …that's enough to choke a horse.' She goes '.. He was very hungry they all were'".*

The residents' experiences in hospital were varied, whether or not they had COVID-19. Many had long hospital stays and were often transferred between hospitals several times, as their condition changed. Some died, despite an early improvement in their condition but others recovered and have since been discharged – some back to St Basil's, to another home or to stay with relatives.

For the relatives it has been a deeply distressing experience, especially for those whose loved ones died. Mostly they do not blame anyone for the outbreak, although some suspect St Basil's was not well prepared. What distresses relatives most was the neglect of basic care which, understandably, they interpret as a lack of respect and betrayal. And they are particularly saddened by their loved one's dying alone, sometimes without having seen their family members, in person, for months.

Many residents' belongings were packed into bags when they were transferred to hospital and some have been lost or taken weeks to be found. Some residents are particularly distressed to have lost all their clothes and having to wear someone else's because their relatives could not buy new ones during the Melbourne lockdown. But they are most distressed by the loss of precious mementoes, of sentimental, rather than monetary value. For the relatives, whose loved ones have passed away, the loss of special garments which they had hoped to be buried in, was particularly distressing.

The continuing grief and trauma suffered by many families was palpable, but many also expressed gratitude for the opportunity to tell their stories and a hope that their experience will contribute to future change and not be unheeded.

Communications

One of the relatives' greatest concerns was the paucity of information about what was happening at St Basil's. From the earliest days of the outbreak, St Basil's phones were often not answered despite repeated calls or were answered by someone who could not answer their question and promised to call back, but often did not.

On 23 July, DoH engaged the Services Australia social work emergency management team to communicate with relatives. Initially an outbound call service was established, to provide generic information. Soon after that, an 1800 number was established for inbound calls to which (at least some of) St Basil's phones were diverted. This took pressure off agency staff who struggled to keep up with the high volume of calls. Some inbound calls were dealt with by a call centre, using a script, others were triaged and forwarded to St Basil's or the social work service, if appropriate. The service has access to a large pool of experienced social workers throughout Australia, who have assisted people during many types of emergency, including bushfires, floods and the COVID-19 outbreak at Newmarch House in Sydney and has well-established systems.

At St Basil's a small team of initially two, then four, RNs was deployed on-site to gather information about the residents to whom they were allocated. They were initially paired with a member of a liaison group, who entered resident information into a spreadsheet and updated it during twice daily calls. The social workers were each allocated a group of families, with whom they would establish rapport and be the conduit for information to and from St Basil's about their loved ones. Twice a day, after shift handovers, social workers would receive updates from a member of the liaison group, then phone the relevant family member. They would also pass on questions from relatives to the communications team for follow up.

For many reasons, this plan took several days to implement. Laptops had to be acquired, email and phone communications protocols established, and spreadsheets developed. The RNs had difficulty accessing paper records and identifying residents. The social workers' initial contact with families was generally received gratefully. Families were relieved to have a point of regular contact. At the same time, some St Basil's staff were calling relatives directly to report changes in a resident condition or a test result, but this was sporadic. Many relatives kept in touch with their loved ones by Facetime or Skype, but this often raised concerns to which relatives wanted answers. Some relatives could not communicate with loved ones who were suffering from dementia or who were hard of hearing.

As information began to be fed back to social workers, relatives became increasingly frustrated that it was often out of date or wrong. Examples were cited by relatives of being told their loved one was comfortable in their room, only to discover he had

been admitted to hospital and was very ill, or that a test result was negative when it was positive (or vice versa). Even relatively innocuous information about a resident was sometimes recognised by relatives as referring to someone else. If they had been in contact with their loved one, relatives often wanted confirmation or to find out what was being done in response to their concerns from someone on site. The social workers tried to find out and call back, but often they could not get answers.

Despite the best efforts of a very expert team, the Services Australia managers told reviewers that they were disappointed by what they felt was a relatively unsatisfactory outcome. A major problem was the fact that the service was not initiated until the third week of the outbreak and the day after the stand-down of St Basil's staff, and it then look some time to establish. By then, the situation at St Basil's was rapidly deteriorating, making it very difficult for the on-site communications team to get timely information from overstretched clinical staff who were unfamiliar with residents. Relatives were becoming increasingly frustrated by the lack of information and their expectations of the new communication system were probably unrealistic. In any event, despite their initial gratitude towards a sympathetic listener they soon became disillusioned by the social workers' being unable – through no fault of their own – to provide up to date and accurate information about their loved one.

Return of St Basil's Staff and Repatriation of Residents

After all residents had been transferred from St Basil's, the independent adviser remained on-site to supervise thorough cleaning of the whole facility and gradual return of the manager, senior nurses and most of the original staff from furlough. The facility began to repatriate residents on 17 September.

By late October, 43 residents had returned, and they and their families are apparently pleased with the service, with one major exception, which is that visiting was still not permitted. Very recently, visits via the 'visiting room' have been reintroduced but, at the time of writing, there are still no face-to-face visits. This has caused increasingly bitter complaints from relatives, who are aware that other RACFs have opened to visiting. As one of the review participants commented: *"They have no risk appetite at the moment at all. I think they've been burnt very badly and are terrified of something similar happening again, so they've been very reluctant to allow visitation."*

Nevertheless, residents can socialise with physical distancing, which they mainly observe, albeit with some lapses. Many have re-established friendship groups and some communal activities. St Basil's advises that it has re-opened face to face visits effective 25 November.

The adviser's assessment of St Basil's recovery is positive. *"I couldn't be more pleased... We've got plenty of staff. St Basil's runs on an RN model, so there's plenty of RN staff and they seem to be quite experienced and quite good. All the staff are quite motivated. The care's been quite good. I've put in place a lot of assessment and monitoring requirements and I haven't had an issue with anything. The repatriation has really gone fairly seamlessly. The care of the residents has been excellent."*

At the time of this report, the adviser remains engaged by St Basil's and the Notice to Agree remains in effect.

The COVID-19 outbreak at Epping Gardens

Introduction

Epping Gardens is located in the northern suburbs of Melbourne, approximately 22 kilometres from the Central Business District. It is owned and operated by Heritage Care Pty Ltd (Heritage Care) which is registered as the Approved Provider within the meaning of the Aged Care Act 1997. The company owns and operates ten residential aged care facilities in Victoria and New South Wales. Greg Reeve is the Chief Executive of Heritage Care.

The Epping Gardens home is registered for 148 places of which 132 places are allocated to residential care and the transition care program. The unit in which a further 16 places are allocated is separately leased and operated by the Northern Health Palliative Care service.

The home opened in February 2018 and received a *commencing service* accreditation period for twelve months until February 2019. In November 2018, the home was subject to a full *site audit* and reviewed by the then Australian Aged Care Quality Agency. It achieved full accreditation (which required the service to meet 44 expected outcomes) until February 2022. At this later site audit, a survey of Consumers' Experience of the Quality of Care and Services was also completed by a number of residents and/or representatives. The home achieved an overall average *agreement score*[21] of 86.7%, measured across ten domains.

At the commencement of the COVID-19 outbreak, there were 119 residents receiving residential or transition care at Epping Gardens. There were ten vacant beds and three which were not in use at that time.

Outbreak Notification and Response

The outbreak at Epping Gardens was formally notified to the DoH at 12:28pm on 20 July, following advice to the PHU earlier on the same day.

The General Manager at Epping Gardens received a call at 9:15am on 20 July from a staff member who advised that she had received notification very late on the previous evening of a positive COVID-19 test result. The staff member was self-isolating at home. During the morning, the facility was also notified that a resident who had been transferred to the Royal Melbourne Hospital on the day prior, had also tested positive to COVID-19. The resident subsequently passed away on 23 July.

Of note, on 20 July, there were 341 new COVID-19 cases reported that day in Victoria and a cumulative total of 2,974 active cases.

[21] *https://www.agedcarequality.gov.au/sites/default/files/media/Epping%20Gardens4573-6-cer.pdf*

On advice from the PHU on 20 July, the General Manager and the Director of Nursing (DoN) immediately isolated residents, enacted the facility's OMP, implemented full PPE, commenced contact tracing and notified the Heritage Care Clinical Services Manager.

In keeping with the response plan, a DoH case manager was appointed to be the key liaison person with Epping Gardens and following receipt of the notification on 21 July, provided immediate follow-up guidance and support to the Epping Gardens management team in the early afternoon. This included advice on matters such as workforce, PPE, laboratory testing, access to the Older Persons Advocacy Network (OPAN), workforce grants and general support and was followed-up with an email later that day. Case managers report to a case lead, a more senior staff member within the DoH.

Consistent with the emergency response, a CFR arrived on-site at 10:30am on 21 July and following an assessment and local discussions, initiated a formal workforce request and PPE increase by early afternoon. CFRs (registered nurses with significant clinical experience) typically provide a high-level situational analysis incorporating an assessment of leadership, IPC and staffing resources whilst they also deliver high quality clinical support.

The CFR expressed concern about the level of IPC preparation, training and leadership capacity, relative to the unfolding situation. The CFR also noted that there was no IPC leadership on-site although Heritage Care had appointed its own IPC co-ordinator in 2019. The IPC coordinator was providing advice remotely.

Following discussions with the management team, the case manager was also initially concerned about comments from some Epping Gardens managers, including the extent to which matters were actually under control, as well as the facility's capacity and capability to access staff. These concerns were later discussed with the Chief Executive.

There was an emerging impression that local leadership was variable and that there was extensive reliance on external resources rather than those available within and across Heritage Care. This reliance included an Epping Gardens plan to transfer residents to hospital if clinically indicated or in the event that insufficient staffing was available at Epping Gardens.

Daily operations meetings commenced on Wednesday 22 July and on Thursday 23 July, the Chief Executive made the case lead aware of an alleged baby shower (which is discussed later in this report). The case lead was advised that the police were immediately notified on the basis that this was an alleged contravention of the restrictions in place at that time, in metropolitan Melbourne and Mitchell Shire.

The daily operations meetings provided a forum to monitor and report on the outbreak and included representation from the Approved Provider, DoH, ACQSC, the

VACRC and the PHU. Attendee interest in this meeting was high and it was reported that there were in excess of 50 participant invitees to these meetings. In addition to this meeting, there were other forums convened by DoH which focused on workforce provision and case management. These meetings were conducted and provided an overview across all outbreaks and as such, did not involve the Approved Provider directly.

Pathology testing

In line with the DoH contract in place, Melbourne Pathology was requested to undertake resident and staff testing on-site at Epping Gardens. Due to the increased demand for pathology testing at that time in Melbourne, testing was scheduled on 20 July to be undertaken on the afternoon of 23 July. Testing at new outbreak sites generally took place in the afternoons and the mornings were used for re-testing as part of an agreed rolling schedule. Scheduling was co-ordinated and prioritised by a scheduling team, established as part of the COVID-19 emergency response within the DoH. A core requirement of the residential care testing program was provision of the patient identification information (for residents and staff) and the recruitment of a local general practitioner to be the key clinical contact person to whom results would be communicated (in addition to other required notifications). These requirements were designed to ensure that patients were correctly identified, specimens were correctly labeled and results were reported with appropriate clinical oversight.

Perceived delays in testing during the early days were causing some concerns for staff at Epping Gardens. The Clinical Services Manager tried to raise these concerns directly with the PHU. She reported making multiple calls and eventually asked the case manager to escalate her request which prompted follow-up from the PHU on the same day. However, it was determined that the scheduled testing would proceed as planned. Delays in testing would ultimately have implications for the timely cohorting of residents.

Prior to the on-site testing taking place at Epping Gardens, it was reported that many staff members had become concerned about identification of COVID-19 in the facility and had opted to use the testing sites and respiratory clinics available in the local community for both symptomatic and asymptomatic testing. The Epping Gardens management team reported that a number of staff were subsequently required to self-isolate, whilst awaiting test results and in turn, staffing shortfalls within the facility were increasing. In addition, prior to the on-site testing commencing later that week, it appears that there was some confusion with regard to the requirement for self-isolation whilst awaiting test results. This would have been compounded by the concerns of individual staff members as well as the delay in on-site testing.

Some resident tests were also conducted and processed locally in accordance with the requesting doctor's wishes. In terms of the overall outbreak monitoring, this created an additional challenge for those with oversight of the outbreak as results for both residents and staff could not be readily or easily accessed in a single results portal. However, with transition to Melbourne Pathology testing for both residents and staff, this matter was quickly and effectively resolved.

Whilst there were steadily increasing positive COVID-19 test notifications from 20 July, the early results from the testing on 23 July quickly identified a significantly escalating situation with more than 80 COVID-19 positive cases (60 residents and 22 staff). Testing was subsequently scheduled for 27 July after which point, the 72 hour testing regime commenced at Epping Gardens. However, due to lack of sufficient documentation and Melbourne Pathology's inability to successfully make timely contact with staff at Epping Gardens, the testing scheduled for 30 July was delayed to 31 July.

Testing generally occurred every three days thereafter and identified continued high rates of infection transmission, with more than 125 COVID-19 positive cases (86 residents and 40 staff) on 31 July and more than 185 COVID-19 positive cases (102 residents and 85 staff) by 3 September. At the conclusion of the outbreak, 103 residents and 86 staff were identified as testing positive to COVID-19.

Infection Prevention and Control

As assessed at accreditation in November 2018, Epping Gardens was compliant with the Infection Control *expected outcome 4.7* with the then accreditation framework requirements for Australian aged care facilities:

> ***4.7 Infection control***
>
> *This expected outcome requires that there is "an effective infection control program".*
>
> ***Assessment of the expected outcome***
>
> *The service meets this expected outcome … The home has processes to support an effective infection control program. The infection control program includes regular assessment of care recipients' clinical care needs in relation to current infections, susceptibility to infections and prevention of infections. Staff and management follow required guidelines for reporting and management of notifiable diseases. Care plans describe specific prevention and management strategies ….*

In addition, there was a series of desktop self-assessments, on-site review and telephone assessments in the period prior to the outbreak, which were conducted by the ACQSC. Whilst the initial self-assessment triggered follow-up, the subsequent

on-site review and phone assessment did not identify concerns or require any further escalation. Indeed, an email from the General Manager to some of the Heritage Care senior management team confirmed this outcome. In addition, based on discussions with several staff members at Heritage Care, including the Chief Executive and Managing Director, it would be fair to say that this assessment, in hindsight, provided a false sense of confidence to them about their level of preparedness.

However, at the time of the self-assessment, the magnitude of the outbreak which ultimately ensued had not been witnessed in Australia. In addition, it was not uncommon for aged care facilities to overestimate their readiness to manage a COVID-19 outbreak. In evidence submitted to the Royal Commission into Aged Care Quality and Safety [22] (special COVID-19 hearing) in August 2020, the Royal Commission heard that 99.5% of services assessed their readiness as either satisfactory or best practice.

Prior to the commencement of the outbreak, Heritage Care reported a number of preparations and interventions which had been put into place as new advice was provided from by the Commonwealth DoH or by the DHHS Victoria. This included the introduction of daily screening of residents, restrictions on visiting, compulsory mask wearing and the implementation of visitor screening on entry to the facility. These updates were communicated to staff via Message Board, an in-house form of communication used across Heritage Care, which is integrated with its eCase electronic resident record. It is considered a reliable form of communication since staff must log-in to enter daily care data and at this stage, new message alerts would be highlighted for them. Updates on screening were provided to residents' families by email. Heritage Care had also appointed an experienced RN, with additional IPC qualifications, as its IPC co-ordinator in mid 2019.

Some family members were concerned that staff members were not wearing masks in the home. However, the review has confirmed that wearing masks only became recommended by DHHS, effective 13 July and that this was implemented on the following day at Epping Gardens.

The review team was also informed that IPC training had been implemented and policies updated. The management team at Epping Gardens advised that whilst they have their own online learning system, they also use the DoH website for education and training of staff. Hand hygiene competency is completed as part of an annual competency assessment required to be completed by all staff. Hand hygiene training records sourced from different data sets (as the online provider changed in early 2020) indicate high levels of compliance with hand hygiene training in 2019 and 2020. Records also indicate that all active staff completed a range of IPC and related

[22] *https://agedcare.royalcommission.gov.au/publications/aged-care-and-covid-19-special-report*

modules (provided online from the DoH platform) in 2020 but fewer than 4% of those were completed prior to the outbreak. In addition, PPE training records specifically indicate that less than 60% of staff completed this training in 2020 prior to the outbreak.

Feedback from Austin Health confirmed that updated policies were in place but also noted that based on their observations, the policies were not well understood by many of the staff delivering direct care.

However, IPC was cited as a significant and ongoing issue by the CFRs at Epping Gardens and this was reinforced following site visits from the IPCON squad and senior clinical staff working on-site from Northern Health. The squad completed a series of on-site visits commencing on 22 July. The IPCON squads generally conduct assessments provide advice and deliver on-site education and instruction to staff. The role of the squads complements the role of the CFRs and provides intensive support to facilities experiencing outbreaks.

Significant issues identified during the visits related to correct PPE training, donning and doffing; zoning and managing potential for cross-contamination; time taken to implement recommendations from prior assessments and delays in cohorting.

Conversely, the Heritage Care senior management team also reported the challenge of responding to and meeting the various requirements and views of many "infection control experts", who often provided conflicting advice at a time when facilities were seeking clarity. They cited at least four sources of IPC advice, in addition to their own recently updated policies and the appointment of their own IPC co-ordinator.

Staff cohorting was in place by 25 July with separate areas identified for staff activities, including amenities. By 26 July, contact tracing identified 110 residents as close-contacts and subsequent testing identified COVID-19 positive residents in all areas of the facility. In discussions with the review team, Heritage Care acknowledged the delay in resident cohorting. The Clinical Services Manager reported that the team was working closely with the Chief Nursing Officer (CNO) from Austin Health to effect the required changes whilst also taking advice from the Infectious Diseases department at Northern Health. Senior staff also reported being on the "back foot" despite their best plans, largely due to delays in testing and the availability of staff to effect the required changes.

On one occasion, in anticipation of the planned cohorting, a group of casual staff were specifically recruited and assigned by the national surge workforce program to Epping Gardens to assist with cohorting. However, after several hours of inaction, the staff were withdrawn, causing much frustration in an environment where staffing resources were a precious commodity. Zones for resident cohorting were established on 26 July whilst cohorting was not completed until Friday 31 July.

Additional staff were commissioned on that day to assist with the process of moving residents, cleaning rooms to the required IPC standards, securing personal belongings and storing items for individual residents. It was described as a time-consuming and resource-intensive process, supported by an additional (cleaning) workforce which required further training and instruction in IPC. However, it was completed, with the Epping Gardens staff extending much gratitude for the support from Austin Health and Northern Health.

Baby shower and birthday party

Baby shower

Following declaration of the COVID-19 outbreak at Epping Gardens, contact tracing commenced in the week beginning 20 July and during the course of these discussions, it was reported that a "baby shower" celebration had taken place on Thursday 16 July. The event took place in the evening and involved six staff members, three of whom were rostered for duty at that time. It was reported that the unauthorised event took place in a vacant room and included four RNs and two PCAs.

This was appropriately considered to be a serious matter and an investigation was initiated and undertaken by the Human Resources Department at Heritage Care. At the time of this report, the reviewers were advised that despite Heritage Care's best efforts, due to the unavailability of staff to participate in the investigation, they have been unable to formally conclude the matter.

However, CCTV footage has confirmed staff entering and exiting the main entrance to attend the event and in some cases, failing to comply with entry screening requirements. All staff alleged to have been involved, remain suspended from duty at Epping Gardens or are unable to participate in the conclusion of the review for other reasons. In the meantime, alleged as a contravention of COVID-19 restrictions, the matter was reported to Victoria Police and the Australian Health Practitioner Regulation Agency (AHPRA). Those proceedings remain underway.

Whilst policy or procedural gaps were not identified, as a matter of continuous improvement and learning, the reviewers were advised that Heritage Care has also reviewed its own policies, procedures and contracts of employment since the baby shower event, to ensure that they provide the authoritative guidance required.

The PHU also advised the review that the source of infection for the outbreak at Epping Gardens has not been established and that the clustering of the cases' onset dates, suggests an unknown upstream case.

Birthday Party

Following media reports and feedback from family members, the reviewers also sought information on a staff "birthday party" which had allegedly taken place in July. Again, this matter had already been investigated by the Human Resources Department at Heritage Care and identified that in fact, a birthday party had not taken place. The investigation revealed that two staff members had shared the same birthday and as is usual practice, they had purchased a birthday cake, which was left in one of the staff fridges for their colleagues to enjoy during break-time. The investigation confirmed that social distancing rules had been observed and that there was no staff gathering. The investigation of this event also confirmed that correct sign-in processes had been undertaken by an off-duty staff member who attended the home to wish one of her colleagues a happy birthday. On arrival to the unit however, she was advised that she should not be present and must leave the home accordingly, which she did.

Noting the serious nature of both the alleged birthday party and baby shower events, the Heritage Care Human Resources Manager advised all staff that any such unlawful activities would be considered gross misconduct and result in termination of employment. She also advised that such activities, which are contrary to the health, welfare and safety of residents, would be reported to the appropriate authorities managing professional standards or health care complaints.

The reviewers believe that both of these events have been taken seriously and investigated and managed appropriately. However, these incidents also raise concerns about the extent to which adverse behaviours are the norm in day to day operations and whether or not, the implications for such activities were well understood by the staff engaged in them.

Workforce and Care Delivery

Background

The staffing model at Epping Gardens is consistent with many aged care providers and comprises RNs, ENs, PCAs and Lifestyle support staff. Discussions with the General Manager confirmed that the average hours of care delivery was between 3.00 and 3.33 hours per resident, per day (HPRPD) between May and July 2020. This is in keeping with the sector-wide benchmarking data[23] published by StewartBrown Advisory on aged care sector performance in March 2020. Whilst indicative and subject to occupancy levels, a review of the master roster, effective 1 June 2020, was also consistent with the HPRPD data provided to the review.

[23] *https://www.stewartbrown.com.au/news-articles/26-aged-care/218-stewartbrown-aged-care-financial-performance-march-2020-survey-sector-report*

However, it was confirmed with the Epping Gardens management team that the roster had been reviewed earlier this year and that staffing had been reduced. This had been highlighted to the reviewers by family members and caused much concern for them. They reported that they noticed the reduction in staffing levels and were concerned that this may have contributed to the outbreak.

The DoN is the senior person responsible for leading and overseeing the delivery of care at Epping Gardens. The DoN reports to the General Manager of Epping Gardens, who in turn reports to the Chief Executive (Heritage Care).

Care delivery is monitored through the eCase electronic resident record. This provides an integrated record including general communication to all users. The system sends electronic alerts to notify of any gaps in care delivery, based on care plans for each resident. Similarly, activity logs provide alerts to the DoN and other authorised users of any variations in care so that they can be monitored.

Medical and allied health services are provided to residents on an "as needs" basis. This generally includes access to general practitioners, medical specialists, the Northern Health RiR service, physiotherapists, dietitians, podiatrists and occupational therapists.

During the outbreak

Staff capacity at Epping Gardens became quickly depleted as increasing numbers of staff were furloughed due to isolation or quarantine, including those who attended the alleged "baby shower" event. Capacity issues were also heightened as a result of staff, who were otherwise well, remaining absent from the site, concerned about working in an active COVID-19 environment. Many reported concerns about the potential impact on their own family and household members. The reviewers were advised that working in the facility during the outbreak, with heightened expectations and increased demands, was a traumatic experience for even the most experienced staff. This was further confirmed when despite incentives offered to staff in other Heritage Care facilities, additional staff could not be identified to assist.

Epping Gardens did not have a formal surge workforce plan in place other than a reliance on its own casual staff pool. Management staff advised that there were plans in place to grow this pool but current numbers were limited. Advice had been regularly provided to the aged care sector through DoH circulars, which included specific information and reports on previous outbreaks in residential care. However, the emergency response at Epping Gardens was immediately compromised in the absence of its own surge workforce arrangements. The Chief Executive also expressed concern that he did not want to destabilise other homes by deploying staff to sites with a declared outbreak. In any event, the review was also told that there was limited (excess) capacity available at other Heritage Care sites.

However, in its own OMP, there is a directly referenced link to the Communicable Diseases Network of Australia (CDNA) guidelines which state:

Workforce Management Facilities should have a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work. Health care workers may also require exclusion from the workplace if they have returned from international travel, and such requirements will impact the workforce nationally. RCF should regularly review the CDNA National Guideline for requirements relating to the exclusion of healthcare workers from clinical settings. The workforce management plan should be able to cover a 20-30% staff absentee rate. Developing and maintaining a contact list for casual staff members or external nursing agencies is essential to timely activation of a surge workforce should an outbreak occur. Surge workforce staff should be appropriately educated and orientated to the function of the unit prior to commencing work. Leave planning should also consider the current nature of the pandemic and ongoing outbreaks.[24]

In addition, the OMP noted that, beyond its own casual pool and part time staff, the facility relied on the surge workforce provided through the DoH. The review also noted that Epping Gardens had engaged Crewe Sharpe Medical as its preferred provider of agency staff. The Chief Executive also reported to reviewers that he understood that additional hospital beds had been made available in the health sector, for the purpose of caring for residents who tested positive to COVID-19.

The staffing crisis escalated quickly from 22 July and by 24 July, Epping Gardens believed that it could only safely provide staff to care for approximately 30% of its usual capacity. Concerns were rising because even where surge workforce staff were scheduled to work, in some cases, they failed to attend. This was a recurring issue and it was escalated through to the surge workforce area within the DoH, where it was further raised with workforce providers.

As regular staffing became depleted, it was decided to revert to paper record keeping. This occurred for a period of approximately ten days. During this period, paper records were created and subsequently, the data was entered into the eCase system. Whilst system access was easy to arrange, teaching and training high numbers of staff was a significant challenge, as well as a huge distraction from higher-order priorities. In the short term, this created issues for those accessing the system to provide updates to family members as well as those accessing the system to monitor care delivery. However, it was noted that the alternative system worked well at a practical level.

[24] *https://www.health.gov.au/sites/default/files/documents/2020/06/coronavirus-covid-19-guidelines-for-outbreaks-in-residential-care-facilities.*

As the staffing crisis escalated, it was decided to implement twelve-hour shifts to conserve available staffing resources. However, with concern for the care and safety of residents and depleted staffing levels, the Chief Executive issued a directive on the afternoon of 24 July requiring that the management team at Epping Gardens "… *identify all high risk residents, in terms of their clinical need and comorbidities … to be transferred to Northern Health by COB today …"*

Whilst this did not eventuate, some residents had already been transferred to hospital and the case lead from the DoH wrote to the Chief Executive on Monday 27 July reminding Heritage Care of its care obligations and that hospital transfer should not be the default operating position. The case lead further advised that specialists from Northern Health would be on site to conduct resident assessments and that both DoH and DHHS were reviewing workforce requirements for Epping Gardens as a priority. By this time, the reviewers noted that active cases in Victoria were rapidly approaching 4,600 and the demand on surge workforce requirements was growing exponentially, as increasing infections took hold across the aged care sector.

Staffing levels were critically low at the commencement of the morning shift on Monday 27 July. There were only two regular staff from Epping Gardens along with a further two agency staff, comprising approximately one quarter of the regular staffing roster for a morning shift. At that stage, there were more than 100 residents to care for. Early that day, the Clinical Services Manager called 000 to instigate emergency transfers of residents, concerned that the staffing levels would continue to decline in the coming days. The service requested transfer of all residents who had tested positive to COVID-19 to hospital. Ambulance Victoria confirmed that a call was received to transfer residents. Whilst emergency transfers did occur (and had been occurring in the days immediately before), these were based on clinical assessments at Epping Gardens or emergency calls from general practitioners or family members. Consistent with advice from DoH to the Chief Executive, Ambulance Victoria deployed a Health Incident Commander later that day to co-ordinate emergency hospital transfers in conjunction with the assessments of clinical staff.

Northern Health also redirected its in-reach team (as it was en route to another aged care facility) to Epping Gardens early on 27 July. The team of mainly RNs assisted with medication management and the delivery of resident care.

Earlier that day, 110 residents had been deemed to be close-contacts and the IPCON Squad had also been on site providing support, in addition to the CFR. Staff at Epping Gardens were reportedly overwhelmed and surge workforce staff due to provide additional cleaning support, refused to enter the facility, citing concerns with IPC.

The Heritage Care senior management team relocated to Epping Gardens on Monday 27 July to provide additional support. This included the Chief Executive , the

Clinical Services Manager, the Human Resources Manager, the National Quality Manager, the Operations Manager (NSW), Quality RN Officer and the IPC co-ordinator.

Late on Monday 27 July, Austin Health was requested to provide clinical support to Epping Gardens. Under the leadership of the CNO at Austin Health, a small team was assembled late into the evening and was scheduled to provide support on the following day. The team comprised experienced clinical nurses, DoNs and Nurse Managers. During that same day, geriatricians were on-site at Epping Gardens undertaking assessments of residents whilst the IPCON squad was also on-site providing support, in particular, with respect to IPC.

The Austin Health team arrived on Tuesday 28 July. They were distressed at what they observed during their first day at Epping Gardens. They held concerns for the level of care being provided and reflected that there was no visible leadership on-site. They reported meal trays piling up and being left untouched in residents' rooms and that residents were also showing signs of dehydration. These observations were echoed by staff from Northern Health who also reported inadequate hydration and nutrition for residents and concerns about personal care related to hygiene and continence management. Northern Health medical specialists also noted that some residents were declining and Austin Health staff observed lack of organisation and clear direction around PPE in a COVID-19 environment.

In the ensuing days, additional workforce staffing was also made available through the national DoH surge workforce program (which had been providing staff since the week prior), Northern Health, Austin Health, Ramsay Health Care and the ADF. There was significant feedback to the review team that many of the additional workforce staff did not have aged care experience. This was reflected in the specific example of a surge worker being unable to assist a resident with a continence aid. The quality of surge workforce staffing was variable and inconsistent. Exacerbating the situation was that many surge workers scheduled did not attend for duty. Anecdotal feedback from the senior management team at Heritage Care suggested that many prospective staff were concerned about working in an active COVID-19 environment and sometimes unaware of the outbreak until they arrived. As highlighted previously, demands for surge workforce continued to grow in aged care services across metropolitan Melbourne as COVID-19 transmission increased. The reviewers note that there are limitations to the size of a suitably skilled workforce in such dire circumstances.

Media and family presence was increasing at Epping Gardens and given the rising tensions, a security officer was deployed to the site to help maintain a safe environment for staff and residents, working and being cared for in a challenging and often frenzied environment.

On return to Austin Health later on 28 July, the Austin team's experienced staff were brought to tears debriefing with Austin Health's CNO. The CNO later attended Epping Gardens with a DoN from Austin Health. The CNO stayed late into the evening so that she could observe what was occurring in the home and interact with night staff. Her colleague DoN confirmed that she would return the following morning to provide continued support and oversight at Epping Gardens. The CNO reported her observations that she saw teams of very capable nurses working together in various sections but that the site was lacking overall co-ordination.

By 29 July, all Epping Gardens clinical and support staff had been furloughed or were absent with the exception of the General Manager, Receptionist and Maintenance Officer. However, the continued on-site leadership and presence of the CNO and nursing staff from Austin Health, marked a turning point in the outbreak and brought a sense of stability, organisation and clarity. Austin Health also assumed responsibility for rostering and established a care model with RNs leading each section of the facility. This was supported by the design and implementation of a brief induction for all new (largely surge workforce) staff arriving at the facility. Austin Health also worked closely with physicians in geriatric medicine and infectious diseases from Northern Health, as well as with the Heritage Care senior management team members

Medical care during the outbreak

During the course of the outbreak, general practitioner consultations were undertaken via telehealth and residents requiring on-site assessment were reviewed by the geriatricians from the Northern Health RiR Program. Northern Health had existing working relationships in place as it also operates its palliative care unit on site at Epping Gardens and provides transition care program beds at the site. Epping Gardens told the reviewers of the existing protocols in place for suspect COVID-19 cases amongst residents and the immediate engagement of the RiR team. These close working relationships proved invaluable during the outbreak, with increasing presence from Northern Health specialists as the situation evolved.

Command and Control

Lack of effective leadership at Epping Gardens was of increasing concern to the DoH and DHHS and the ACQSC. DoH staff observed that leadership was variable and that it didn't always reflect the appropriate prioritisation of required outcomes, including attendance at the daily operational meetings, which were in place to provide co-ordination of the unfolding and escalating emergency.

There were specific concerns about delayed and effective cohorting of residents, IPC, lack of containment and decision making with respect to the care of residents.

Notwithstanding the provision of the surge workforce, there were issues with respect to clinical leadership, organisation and oversight.

As outlined earlier, on 27 July, the Heritage Care senior management team, which had been previously working off-site, relocated to Epping Gardens to provide further support and advice on Heritage Care's systems and processes including its electronic resident record.

At the same time, there were escalating concerns expressed by family members to the media and the ACQSC. The presence of the on-site media caused anxiety for staff attempting to access Epping Gardens whilst family members were increasingly fearful for their loved ones. Following consideration of the evolving situation at Epping Gardens, the ACQSC issued Heritage Care with a Notice to Agree (NTA) on Tuesday 28 July. Accepting the NTA avoids the imposition of a revocation sanction under *Aged Care Quality and Safety Commission Act 2018* and carries with it, stringent requirements which must be met. Importantly, this included, *inter alia*, the appointment of an eligible adviser and a requirement to comply with advice, recommendations and directions from Victorian health authorities. Notwithstanding their surprise with the NTA being issued, Heritage Care accepted it and formally agreed to the conditions outlined. An adviser was appointed and commenced on site on the following day.

Following Austin Health's engagement with Epping Gardens on the day prior, the health service's CNO was subsequently asked to also assume the role of Incident Controller at Epping Gardens, in order to provide overall command and control of the outbreak emergency. She arrived to assume this role on the morning of Wednesday 29 July.

However, the Chief Executive was also scheduled to be on site later that morning and there was initial confusion about overlap of roles and responsibilities of the Incident Controller and the Approved Provider. The Chief Executive had requested that no decisions be made until he arrived. Immediately following his arrival, he called a group meeting with key people on site and set about gathering information, assembling people and managing matters, without due regard for the role of the Incident Controller. In turn, this led to some frustration and consternation between the parties and a sense that valuable time was being lost. This was further discussed with staff of the ACQSC and it was subsequently, mutually agreed, that the Incident Controller would remain on-site and work with Heritage Care's National Quality Manager, the Clinical Services Manager and the newly appointed advisor. The Chief Executive told the reviewers that he valued the CNO's input and asked the adviser to provide his full support to the Incident Controller. Accordingly, he left the site to provide space for the Incident Controller and advised the ACQSC of this. He remained involved through remote access.

The Chief Executive provided full access to Heritage Care systems to the adviser. With many people on site and lack of clarity in leadership roles observed on his first day, the adviser recalled the pressing need for clear direction, describing the presenting scenes as disorganised and chaotic.

Resident transfers to hospital had already commenced at that time and during the period 27 to 29 July, more than 50 residents had been transferred to numerous public and private hospitals based on clinical assessment. CFRs and the RiR service from Northern Health were on site at Epping Gardens providing clinical assessments of residents and Ambulance Victoria was on-site to provide clear leadership and direction with respect to the co-ordination of all hospital transfers. An Incident Health Commander was deployed to Epping Gardens as part of Ambulance Victoria's emergency response. Concerned for the deteriorating situation at Epping Gardens, families had also initiated 000 calls in order to have their loved ones transferred to hospital.

The subsequent reduction in the numbers of residents on site ensured that the staffing levels were adequate to meet the ongoing care needs of the residents. At the time of the adviser's commencement, there were just 35 residents remaining on-site who had returned negative COVID-19 tests. A further 11 residents subsequently became COVID-19 positive.

Resident & Family Experience

Reviewers contacted Epping Gardens' residents and their representatives, inviting them to meet in small groups, via videoconference or provide written submissions to share their experiences. Three family videoconferences were conducted, each with a maximum of four or five family representatives from nine families. Six written submissions were also received. Group and resident meetings were professionally facilitated. The meeting with residents at Epping Gardens was held on site, where 13 residents engaged in the discussion and provided reflections on the outbreak. Participants endeavoured to be constructive and balanced in their feedback but also saw this as an opportunity to share "their story", a process which many commented on as being valuable in itself. Whilst the reviewers cannot adequately convey the pain, emotional toll, grief and loss endured by so many family members, it is incumbent on the review to convey the recurring issues and concerns raised by them.

Pre-outbreak

In the pre-outbreak period, there were mixed views about how Epping Gardens was operating. Many commented on why it became their home of choice and what was important to them and their loved ones. For some, it was about the physical environment and the ambience and for others, it was more about location and

accessibility for families and friends. Epping Gardens is an immaculately presented home with large single rooms, all with ensuite bathrooms and an abundance of space. Set on two levels, it also enjoys additional amenities such as a cinema, hairdresser and a café on site.

One of the participants said that COVID-19 had *"… thrown a spanner in the works"* and disrupted life as they knew it at Epping Gardens. Others described the issues they experienced as a result of the COVID-19 outbreak, as an extension of changes and a gradual decline they had observed over time. But whatever their predilection, they were united in their distress and shared grief for what had occurred during the outbreak, including the loss of many loved ones in this tumultuous period in their lives.

Key changes observed in the pre-outbreak period by participants, related to reductions in staffing and the declining level of cleanliness. Staffing levels at Epping Gardens are discussed earlier in this report. One family member reported having to clean their loved one's room, as it was not cleaned to the required standard, including the bathroom. However, whilst this was not the view of all those that participated, it was a dominant theme and raised concerns for family members as to whether these preconditions had contributed to the outbreak. There was also mixed feedback on timely follow-up on complaints or feedback to the home, highlighting the inconsistencies experienced by different families. There were many particular concerns with regard to whether or not residents were receiving consistently good standards of personal and clinical care.

Another concern with regard to the environment was the extent to which visitors were properly screened on entering the facility. Whilst it is clear that the screening processes were in place and that security provisions should restrict unauthorised entry, the reviewers were informed of incidents where family members had entered the home without restriction. Family members also highlighted that entry processes had subsequently become "tighter". However, the lapses in monitored access affected their level of confidence in the process. This matter was raised by the reviewers with the Epping Gardens management team members. They responded that they were unaware of such issues and whilst accepting that this had occurred, advised that this should not have been possible. During business hours, the main entrance is attended by a receptionist and after hours, the building is accessible though staff access-fobs. It was mentioned that from time to time, a visitor may enter via the entrance at the same as a staff member is granted entry via their access fob.

During the outbreak

At the outset of the outbreak, the alleged baby shower and birthday party events caused concerns for family members, many of whom learned of this via media in the

very early days after the outbreak was declared. They said that they felt let down that they could not visit their loved ones during the lockdown and yet they perceived that staff gatherings were permitted. They reported this activity as being disrespectful to residents receiving care at Epping Gardens. However, the response to the unauthorised gathering from Heritage Care was taken seriously. The Chief Executive reported the alleged event to Victoria Police and the DoH as a priority. Further, the alleged incidents were managed as a serious conduct issue by Heritage Care (including the suspension of staff pending an investigation) as discussed earlier in this report.

Care matters

As regular staffing levels started to decline and staff were replaced (where possible) largely by a surge workforce (including agency, ADF, private hospital operators and public health services), some family members reported declining conditions and experience in the home. Some residents were able to keep in contact with their family members independently, by phone, which meant that they were less reliant on other resources to manage those communications and updates between residents and family members.

One family member reported that his father could not get timely assistance to be taken to the bathroom and as a result, had to urinate in his clothes. Another family member reported that her mother had reported to her that she had vomited and had soiled the bed linen. The family member subsequently called the home in order to arrange care and later found out that only one sheet had been changed. She reported that it took another call for her mother's pillowcase and sheet to be changed. Other families reported that they had observed shortages of linen supplies prior to the outbreak.

Other residents told their family members that they were not receiving support with care and in particular, with regard to washes, whilst showers of residents with COVID-19 were not permitted owing to concerns about transmission. This extended to being unable to wash hands before and after meals as well as having handles on walking frames not cleaned when residents had been to the bathroom. Drink bottles seemingly went unwashed and were not filled with fresh drinking water. Family members told the review that their loved ones were not being assisted with meals. Others felt that whilst they had been proactive with assisting their loved ones themselves, they felt the reverse was happening at Epping Gardens. They said their loved ones became deconditioned. Clinical staff had also observed residents who were dehydrated. Residents also reported missing meals and delayed or missing medications. Family members further reported that there were delays responding to call-bells and occasions when residents would call the main reception number to request assistance as the call-bells were unanswered. Some residents reported to

family members that they had left their rooms to get water and described the home as *"… looking like it's been hit by a bomb."*

One family member was so alarmed that she made contact with state and federal Members of Parliament to express her concern with the unfolding situation and its impact on her loved one. Others were writing directly to managers and senior staff at Epping Gardens, raising their queries about the clarity and detail of the email updates being provided to them. Family members were desperate for updated and accurate information and often more concerned as they became aware of stories circulating in the radio, television, print and social media.

With on-site medical specialist assessments underway, there were multiple hospital transfers in the week commencing 27 July, which often continued late in the day and into the night. Whilst families were alarmed to sometimes receive notification of impending hospital transfers during the night, many family members also reported satisfaction and comfort knowing that their loved ones were being transferred in order to receive the best possible care. Losing confidence in Epping Gardens' capacity to manage the outbreak, some were also insistent on hospital transfers for their loved ones. However, some also expressed concerns that the focus appeared to be on the resident's age and that palliation was more readily discussed than recovery. One family member said, *"She went down … her oxygen levels plummeted. Again, not eating … I got a call from one of the doctors advising me that we need to, as a family, start thinking about palliative care. And I said to him, 'she's sick, she's not dead. Why don't we focus on her getting better?' And he seemed immune to death, as if that was just normal – my mum's 93 – well, that's what happens when you get to that age".*

Another family member reported his loved one's experience in one of the receiving hospitals which had a lasting impact on him:

"And mum did say at one stage, to the nursing staff at the hospital, that she needed more help and they couldn't get a psychologist in to help her because she said she felt like she needed – her mental health was downhill, she felt like someone else was in her body that wasn't her. And she said, 'Well, if I can't get help, I may as well just drop the ball and not eat anything.' And they said, 'Well, that's quite within your rights to do that.' And I thought that was a terrible thing to tell a woman who's panicking and delirious. And she came home to me and started saying the same thing and that she was allowed to go, the hospital staff had told her that she didn't have to eat. And that's what she took from those comments, her life was useless."

Residents reported being "whisked away" without time to collect any personal effects including their own toothbrush and reading glasses but felt they were in good hands once they had been transferred to hospital. They also reported missing their loved ones during the restricted visiting regimes imposed during the COVID-19

outbreak. In particular, they were sad to miss special occasions like significant wedding anniversaries and found the regime too restrictive during weekends when there was generally less activity in the home itself. Visiting restrictions took their toll on families distressed at not being able to visit. As one family member said, it's hard to be confident with what is happening when you are unable to visit loved ones:

"while pre-lockdown we had been able to see the way mum was being looked after and we were able to interact with the staff to make sure she was looked after ….But once they closed the doors due to COVID, that's when we lost absolute contact … and that's when I guess I feel like they abused my trust in them".

Whether or not the abuse of trust is substantiated, the reviewers note the significance of the impact of visitor restrictions on residents and families.

One of the family members spoke about issues with the lack of timely diabetic care required by his mother, identifying that the critical routine became destabilised during the early part of the outbreak. This led to his mother becoming increasingly anxious. Later that day, he called his mum but her phone was unanswered and he later learned that she had been transferred to Cabrini Hospital (Elsternwick). He called Cabrini, desperate to locate her, only to find that as her health had deteriorated, she had been transferred to Epworth Hospital instead. In another similar case, a family member was advised that his father had been transferred to hospital. Having then called the receiving hospital, he was alarmed to find he was not there and ultimately established that he was still at Epping Gardens. The high volume of hospital transfers for residents from Epping Gardens was an enormous logistical challenge and without the presence of regular staff who were familiar with the residents, these transfers required a higher degree of co-ordination. Notwithstanding the delivery of safe and appropriate clinical care, the lack of effective and accurate communication was of increasing concern to family members, who felt dislocated from their loved ones.

Communication matters

Many family members reported that it was hard to get timely information at the beginning of the outbreak and that they would call on numerous occasions, often without a response from Epping Gardens. For some family members, where their loved one did not speak English, keeping in touch not only allowed important contact, it also provided a "voice" for the resident who could communicate any concerns or advocate for follow-up if it was required. Many residents were also transferred to multiple hospitals and the communication from hospitals to family members varied. The overwhelming message from family members was that they want to be kept informed with regular and accurate information and when they request information, they rightfully expect a timely response.

Immediately following the outbreak, the key means of communication was primarily via a daily email, with individual calls made to family members as residents became unwell or were being transferred to hospital. Heritage Care established an in-house communications team for which there was overwhelming demand. In addition, given the dynamic nature of live media, updates were often in the public arena prior to family members hearing directly from Epping Gardens. Information from the OPAN was also provided to Epping Gardens and advocates were allocated to assist the facility as required. With increasing media focus, for some families, this fuelled their concerns and heightened their anxiety about what was occurring in the facility. In turn, this increased complaint notifications to the ACQSC and gave rise to an increased media presence.

During the outbreak, there was a series of Zoom meetings, providing information to families. This also provided a forum through which the ACQSC, the Approved Provider, The DoH and Minister for Aged Care and Senior Australians could also directly engage with family members and provide assurances on important follow-up matters. From the Minister, this included a commitment to improve communications to families. Improvements subsequently occurred and the ACQSC established rigorous monitoring to ensure that it was maintained.

Services Australia was also engaged to provide support for enhancing communications with family members through outbound calls and establishing contact with all families. However, Epping Gardens assumed total responsibility for family contact with effect from 31 July with an enhanced in-house team.

This change was welcomed by family members with one family reporting, "[name] *from Heritage Care in Sydney … consistently rang to see how we were and if he could do anything for us. His calls were extremely supportive and reassuring*". This model ensured that there was regular contact with family members.

It was also often reported and subsequently verified, that many staff speak English as a second language. In some cases, this makes communication more challenging, especially with older people who may have difficulty hearing. Some family members reported that staff often talked and joked between themselves in their own languages. The reviewers noted that this is further complicated during COVID-19 when many staff are wearing masks, eye wear and full PPE. Conveying her anxiety, one resident described her experience to a family member as *"… the Martians have taken over my room"* whilst another described it as "*scary*".

End of Life Care

Some residents sadly passed away at Epping Gardens whilst others died in hospitals to which they had been transferred. Whilst practices did vary, family members expressed concern at not being able to visit their loved ones and this was exacerbated due to restrictions imposing limited numbers of people able to attend

the funeral of their loved one. As described by one family member, *"… You can never fix that but to this minute [name] still hasn't seen his sister from the day we did the funeral. This is what's basically killing everybody at the moment."* Being unable to say their final farewells was distressing and the trauma and grief of having lost a loved one during COVID-19 was still very raw.

Some family members also described the extraordinary efforts that individual staff went to in order to keep families connected during their loved one's final hours and days. They also praised the exceptional efforts of staff who often went to significant trouble to find suitable alternative meal options for their loved ones, who had a decreased appetite, consistent with being COVID-19 positive.

Missing personal belongings

With the multiple resident movements (within and outside Epping Gardens), there were a number of residents and family members who reported missing personal items, including valuables. This was a recurring theme identified by the review. Some reported that this had also occurred prior to the COVID-19 outbreak. Epping Gardens staff responded that they were aware of some of these matters and that they had invested enormous time and effort endeavouring to locate lost items and in some cases, also replacing them. For some though, the lost items were irreplaceable. One family member reported the loss of a significant piece of jewellery which had been physically separated from another piece, left on the resident's bedside table. The reviewers noted that processes for collection and storage of personal effects need to be improved as such findings are a recurring theme.

The experience of residents and families at Epping Gardens is ultimately the product of inputs, processes and outcomes related to the COVID-19 outbreak. Some of these experiences are unexpected and unintended. As with other aspects of this review, it is the details of these which need to be understood, so that learnings can be considered and applied to the management of similar events in the future.

Transition to 'COVID normal'

As outlined earlier, the adviser engaged under the terms of the NTA, commenced with effect from 29 July and since that time, he has worked closely and collaboratively with all parties at Epping Gardens, including the then Incident Controller (CNO from Austin Health).

With many residents having been transferred to public and private hospitals, staffing levels had increased markedly and the additional workforce enabled close to 'one to one' care staffing ratios. In addition, ongoing support from Northern Health, ADF and some public health services ensured maintenance of increased staffing levels throughout August 2020.

As the situation at Epping Gardens stabilised and staffing issues were being effectively managed, Austin Health's surge staffing resources subsequently ceased on Tuesday 4 August. However, the CNO provided daily support on site for a further period until mid-August. This ongoing support effected a smooth transition and assisted with the establishment of new and improved ways of working.

The adviser has continued to drive improvements in daily operations and care delivery and provides regular progress reports to the ACQSC focusing on the requirements and terms of the Notice to Agree.

The adviser reported ongoing improvements in staff morale as staff returned from furlough and that a comprehensive review of the staffing roster had been undertaken to ensure that residents' care needs could be met. Northern Health continued to provide nursing staff to support Epping Gardens, as staff began to return from furlough. As regular staff returned, training was a major focus, along with the recruitment of RNs to consult with residents and review their care plans. At the end of September, more than 90% of regular rostered shifts were being delivered by Heritage Care staff and reliance on agency staff was reducing.

Subsequent to the outbreak and having met the required criteria, Epping Gardens moved into "enhanced surveillance" effective 27 August and the site was declared "outbreak free" on 10 September, 52 days following the first notification to the DoH.

For residents wishing to return, repatriation of residents back to Epping Gardens is now complete and life is returning to the new COVID normal. Based on their experience, some residents have elected not to return to Epping Gardens. The reviewers note that visiting has now recommenced, a major factor for residents and their families and friends.

At the time of this report, the adviser remains engaged by Heritage Care at Epping Gardens and the NTA remains in effect.

Reflections from Heritage Care

The reviewers met with Tony Antonopoulos (Managing Director) of Heritage Care to reflect on the outbreak at Epping Gardens.

He confirmed concerns about staffing and its sudden depletion on 27 July and a view that Epping Gardens was not receiving the external support it required to address and ease the situation at that time. He also confirmed the level of confidence experienced as a result of the positive outcome of the ACQSC desktop and site-specific review at Epping Gardens, to evaluate the COVID-19 outbreak preparedness.

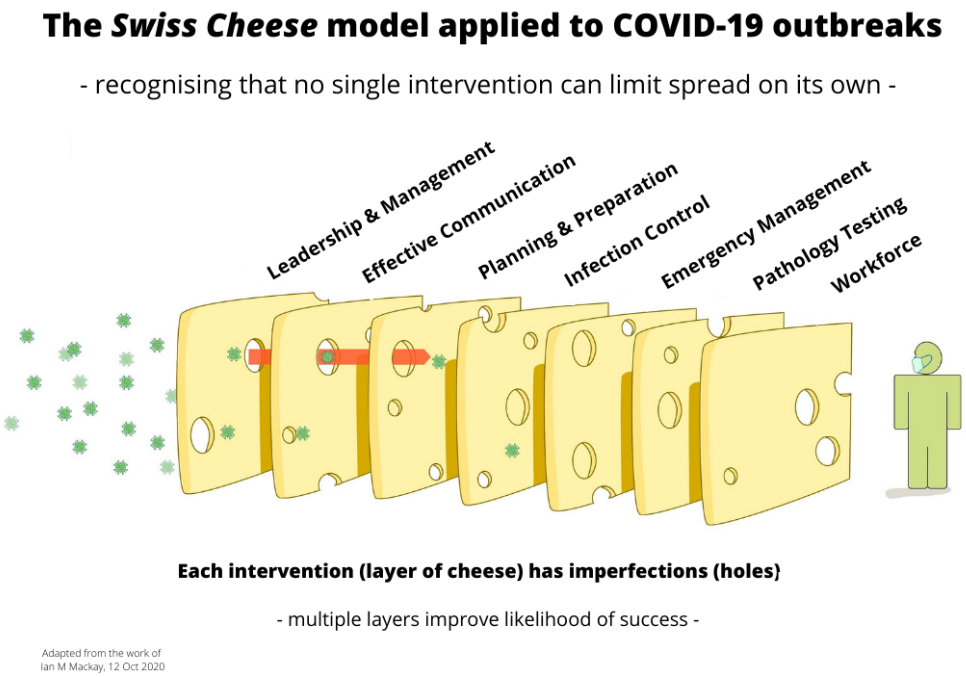
With regard to the situation at Epping Gardens, he noted the stressful conditions under which staff had continued to work stating that *"… they were telling us that they broke down in tears at the media reporting about what was going on in the facility*". He expressed the organisation's commitment to best practice, citing guidelines incorporated into policies and procedures from the Joanna Briggs Institute[25].

Discussing his reflections on what could be done better, he distinguished matters which an organisation could reasonably control and those it could not. He expressed an unequivocal desire to communicate more effectively with residents and families during a crisis and recognised the shortfalls of what had occurred at Epping Gardens:

"We feel desperately sorry, for every single one of them that we couldn't – we were in a war. It was like, we were desperately trying to save lives in that week, particularly from the 27th onwards, right. It was – I can't describe to you how desperate the situation was behind the scene; how helpless we felt and how isolated that we felt. And absolutely understand all of the families responses and the grief, the frustration, all of that, completely understandable. For 18 years, I've taken pride in what I've been able to do for our residents in aged care, Heritage Care, right. This is the one time, the one event, where I felt I'm completely helpless. It was the worst feeling I've ever had in my life in that sense".

[25] *https://www.healthdirect.gov.au/partners/joanna-briggs-institute*

Learnings & Considerations



Using the *Swiss Cheese* model described earlier in the report, the reviewers have identified a number of imperfections (holes) in different parts of the aged care sector (slices of cheese) which, in turn, have weakened its defences against COVID-19. Describing these imperfections gives rise to learnings and considerations as to how each slice of cheese could be strengthened.

Notwithstanding that some of these learnings have already been recognised and acted on, independently, it is worth reiterating them in the context of these outbreaks. Continuing the *Swiss Cheese* metaphor – the learnings from the review and some considerations are documented under each of the "slices" of cheese:

Leadership & Management

Finding: Leadership and management faltered in different ways in both facilities and unable to meet the challenge of COVID-19.

Learning: Effective leadership in the context of the COVID-19 pandemic (or any a potential crisis) requires an understanding of the leader's role and a defined command and control structure. The leadership team must be willing to seek and act on expert advice and collaborate, openly, with external agencies. Organisation-wide culture reflects the effectiveness of its leadership. Effective clinical governance drives improvements in quality and safety.

A Notice to Agree (issued by the Aged Care Quality and Safety Commission) seems an unlikely tool with which to fix an escalating crisis, but it functions as a circuit breaker. Senior DHHS officials told reviewers the Victorian Aged Care Response Centre often observed immediate performance improvement, in response to a Notice to Agree.

Considerations: The roles and responsibilities of Approved Providers in leading the response to COVID-19 or other potential crises in aged care should be clearly defined. Governing bodies (however defined) of Approved Providers must actively participate in clinical governance. Ongoing dialogue between Approved Providers and regulators, to define relationships and qualities of leadership, may limit future need for Notices to Agree.

Effective Communication

Finding (a): Communications with consumers were delayed and often inaccurate.

Learning (a): Residents and their families were often the last to be informed about the progress and implications of the outbreaks. With face-to-face visits restricted, there was an increased need for effective communications. Major shortfalls in delivery on expectations prompted relatives to contact media and members of parliament, which often provoked a vicious cycle of alarm, recrimination and 'knee-jerk' responses often fuelled by rumour. Advocacy organisations and Services Australia played pivotal roles in communications but their access to timely information was also often limited or delayed.

Consideration (a): There is a clear need for a proactive communication strategy ready for immediate activation to provide timely, accurate information for residents, their families and the general public e.g. by personalised messaging to relatives and regular release via conventional and/or social media. Even when information is limited or rapidly changing, transparency is most likely to promote confidence and minimise fear, conflict and reputational damage. Immediate access to and allocation of emergency 1800 numbers, would provide timely support and advice to families seeking urgent updates on their loved ones.

Visiting restrictions must be examined closely to ensure that visiting is optimised at all times to the extent that it is safe to do so. This would relieve the pressure of alternative forms of communications for concerned family members.

Finding (b): Early in the second COVID-19 wave in Victoria, some communications between Victorian and Commonwealth government agencies and affected facilities were disjointed.

Learning (b): Poor communications between government agencies and facilities sometimes caused delay, misunderstanding and duplication of effort. The central

co-ordinating role of the Victorian Aged Care Response Centre (VACRC) was a major driver in facilitating effective interagency communications.

Consideration (b): The operations of VACRC or its equivalent in other jurisdictions should continue at a level which allows prompt reactivation in the face of renewed COVID-19 transmission or other risk to aged care services. Advice to Approved Providers must be streamlined.

Planning and Preparation

Finding (a): Emergency planning and preparation was untested and reactive.

Learning (a): Despite numerous guidelines, frameworks and directions provided by the government agencies and Aged Care Quality and Safety Commission, site-specific outbreak management plans had not been developed and trialled in either facility under review. Testing and practicing emergency plans will ensure that a plan is fit for purpose.

Consideration (a): A detailed, site-specific outbreak management plan, including command and control, communications, infection prevention and control and workforce strategies, and how to activate them, must be developed, tested and updated regularly.

Finding (b): Arrangements and indications for transfer of residents to hospital were poorly defined at the time of these outbreaks.

Learning (b): *Ad hoc* decisions by facilities to initiate emergency transfers of resident without appropriate medical indications caused great distress and potential harm to residents and stress on already overburdened systems. This situation was ameliorated by the establishment of local 'hubs' and proactive relationships between facilities and hospital services, and coordination by VACRC.

Consideration (b): There should be no restriction on transfer of residents to hospital on the basis of clinical need. Other transfers should be planned cooperatively, as required, depending on local circumstances.

Infection Prevention and Control

Finding: Evidence of preCOVID-19 infection prevention and control (IPC) administrative and environmental arrangements, and staff training and competency were limited, despite their having satisfied accreditation requirements.

Learning: Routine IPC education, training and practice in aged care facilities, generally, have been variable, but often rudimentary. Training staff in the stringent IPC measures required to protect residents and staff from COVID-19, is impossible to implement in a crisis, without a pre-existing 'IPC culture'. Inexperienced agency workers had little understanding or practical knowledge of appropriate IPC practice.

Consideration: Residential aged care facilities are now required to employ an IPC clinical lead that is a member of the nursing staff and has completed a recommended IPC course[26]. The roles and responsibilities of the IPC lead need to be fully defined and IPC guidelines, standards and assessment criteria developed for different types of facility. Appropriate physical and administrative controls, adequate financial resources and professional support and continuing staff education and training are required for a sustainable IPC program. Enhanced IPC training and resource requirements should be incorporated into the outbreak preparedness plan.

Emergency Management

Finding: Emergency management within the facilities was compromised to the extent that preparedness was inadequate.

Learning: Planning and preparedness determines the extent to which a facility will be reliant upon external resources. The reviewers' assessments of both St Basil's (single site provider) and Epping Gardens (multi-site provider) confirm that their levels of resilience and self-sufficiency were low, as reflected in failure to rapidly contain infection or maintain adequate care of residents. The public health emergency order to furlough the entire St Basil's workforce, lack of a handover/business continuity plans and inadequate documentation, significantly affected outbreak management.

Consideration: Handover/business continuity plans must be developed to ensure that the Approved Provider maintains operational control and/or adequately informs and supports replacement staff. The Approved Provider must make available current residents' care/clinical records and operational information required to ensure that the safety of residents and staff is not compromised. Business continuity plans should be assessed as part of the Aged Care Quality Standards.

Pathology Testing

Finding: Delayed testing led to corresponding delays in case-detection, contact tracing, appropriate quarantine and cohorting of residents and staff, with adverse impacts on workforce availability and outbreak control.

Learning: Factors contributing to delays in specimen collection and results reporting included: i) delay in appropriate notification of an index case; ii) documentation required for efficient, specimen registration, scheduling and reporting being unavailable or in the wrong format; iii) unprecedented demand for laboratory testing; iv) concern for the safety of collection staff due conditions at the facilities; v) failure to pass on results to workforce managers.

[26] https://www.health.gov.au/initiatives-and-programs/infection-prevention-and-control-leads#about-infection-prevention-and-control-leads

Consideration: Facilities should be aware of requirements for notification of an index case. They should develop resident information in the format required by the laboratory. The doctor ordering tests should ensure results are promptly passed on to facility managers and individual staff members and residents or their nominated representatives.

Workforce

Finding: There was no effective surge workforce planning in either facility.

Learning: Lack of surge workforce planning limits the facility's capacity to manage and contain an outbreak without outside support. Whilst the Commonwealth and State surge workforce planning and capacity have improved, demands on their combined resources, are still likely to exceed supplies during in a large outbreaks. In part this is due to an overall shortage of personal care assistants and nurses experienced in aged care. Hospital nurses are an invaluable resource during and outbreak, if available, but aged care workers are essential to maintain adequate basic care of all residents.

Consideration: Introduction of a suite of innovative roles to be utilised during the course of an outbreak may include: i) *Residential Aged Care Nutrition Assistant* – where allied health students provide nutritional (food and hydration) support for residents; ii) *Residential Aged Care Safety Officer* with a focus on health and safety; iii) the *Residential Aged Care Visiting Assistant* with a focus on assisting physical or virtual visiting.

These roles may provide opportunities for people who are unable to undertake their substantive role in other industries during an outbreak or those who are current students. They might also include residents' family members, who have cared for loved ones before, and often continue to do so after, their admission to a residential aged care facility. They are most familiar with their loved one's needs, were bewildered and frustrated by being excluded during the outbreaks. If they are available, and willing to undertake basic training, they would be an invaluable resource. More recently, consideration has been given to other models such as an 'aged care reserve', a volunteer or standby workforce trained in aged care to provide surge capacity, who would be available in the event of a pandemic. Exploration of these roles should continue.

In summary, as clearly outlined above, imperfections in a single slice of cheese, may not have led to the devastating COVID-19 outbreaks observed at St Basil's and Epping Gardens, but the alignment of imperfections in multiple slices created the "accident opportunity" described by James Reason[27].

[27] *https://www.skybrary.aero/index.php/James_Reason_HF_Model*

Conclusions

At the time of this report, the COVID-19 second wave in Victoria has concluded and as at 27 November 2020, some epidemiologists[28] believe that transmission of the virus has been eliminated in Victoria. This gives great hope, following the trauma and despair of the past few months when COVID-19 was rampant in the community and spread into residential aged care facilities, where some of Victoria's most vulnerable people live.

This review has highlighted some of the multiple factors at play in managing COVID-19 outbreaks and builds on the previous reviews at the Dorothy Henderson Lodge[29] and Newmarch House[30]. Whilst improvements have been observed and new lessons identified, there is an ongoing challenge to drive and embed consistent improvement across the aged care sector.

The sector is always learning and resources are constantly being reviewed, updated and disseminated. However, this review clearly identifies how easily things can go awry and that the preparations needed for such major outbreaks are often significantly underestimated. It also identifies learnings for improvement at a local and sector level.

In undertaking this review, the reviewers have heard firsthand about the impact of these outbreaks on residents and their families and the devastating loss of life. Giving a "voice" to residents and their families is central to this review and when they speak, we must listen. The reviewers have also heard about the huge emotional impact and toll that managing outbreaks can have on the most highly credentialed and credible leaders in the sector. We cannot underestimate the personal impact and sacrifice of leading during a crisis, when effective leadership and clarity is quintessential. And whilst recognising that accountability goes hand in hand with leadership, blame does not drive improvement.

The reviewers did not hear directly from frontline agency staff hired to fill the breach left by furloughed regular staff. They were described by others as generally young and inexperienced. Most had little experience in aged care, and many spoke only basic English. With little preparation or supervision, it is not surprising that many did not stay and those who did, were quite likely traumatised. But relatives described their resilience and kindness - helping residents stay in touch with them by phone or iPad or via an (illicitly) opened window (so an anxious family member outside could shout a greeting). We must not forget them or the dedicated teams of frontline staff,

[28] *https://www.abc.net.au/news/2020-11-27/has-victoria-eliminated-covid-after-28-days-of-zero-new-cases/12923402*
[29] *https://www.health.gov.au/resources/publications/review-of-dorothy-henderson-lodge-covid-19-outbreak*
[30] *https://www.health.gov.au/resources/publications/newmarch-house-covid-19-outbreak-independent-review*

who were sometimes brought to tears by what they saw but simply got on with the task of making it better.

The reviewers noted that Australia's subsequent aged care response capacity has built on the success of the Victorian Aged Care Response Centre, with aged care response centres now being established in all states and territories. Managing the impact of COVID-19 is an exercise of disciplined, ongoing learning and reflection.

Reflecting on the first month of World War I, American historian and author, Barbara Tuchman (1962)[31] famously wrote "*in the midst of war and crisis nothing is as clear or as certain as it appears in hindsight"*.

But with the benefit of hindsight, we can learn and grow. It is now imperative that the sector and those funding the sector, understand what more needs to be done to optimally mitigate such outcomes into the future. As one of the family participants said, *" I hope these reviews do not gather dust like all the others into aged care".*

We agree and we want this report to add to the growing body of knowledge in Australia. Consideration of the observations and learnings in this review, should be a catalyst for review and improvement.

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[31] *https://www.abc.net.au/radionational/programs/archived/hindsight/the-guns-of-august/5617558*

Appendix I

The Reviewers

Professor Gwendolyn (Lyn) Gilbert AO

MBBS MD FRACP FRCPA FASM M Bioethics

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 Network (PHLN), 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. Professor Gilbert is a member of the newly established Aged Care Advisory Group which also provides advice to the Australian Health Protection Principal Committee.

Adjunct Professor Alan Lilly

RPN RGN Grad Dip HSM MHA FCHSM CHE 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. Professor Lilly is a member of the newly established Aged Care Advisory Group which provides advice to the Australian Health Protection Principal Committee.

Appendix II

Summary of Review Participants

Meeting ID	Date	Role or Department	Organisation
1	22-Sep	Case Lead	Department of Health
2	22-Sep	Medical Director	Epworth Healthcare
3	23-Sep	Chief Nursing & Midwifery Officer	Department of Health
4	24-Sep	Case Lead	Department of Health
5	29-Sep	Surge Management Team	St Basil's
6	29-Sep	Surge Management Team	St Basil's
7	29-Sep	Adviser	Epping Gardens
8	29-Sep	Clinical First Responders	Aspen Medical
9	30-Sep	Communications Consultant	Gracosway
10	30-Sep	Commissioner's Team (Epping Gardens)	ACQSC
11	1-Oct	Commissioner's Team (St Basil's)	ACQSC
12	1-Oct	Management Team	Epping Gardens
13	1-Oct	State Manager	Department of Health
14	2-Oct	National Manager	Aspen Medical
15	2-Oct	Surge Workforce Program	Department of Health
16	5-Oct	Support Office	Heritage Care
17	6-Oct	Family Members	Epping Gardens
18	6-Oct	Family Members	St Basil's
19	7-Oct	Family Members	Epping Gardens
20	8-Oct	Case Lead	Department of Health
21	9-Oct	Family Members	St Basil's
22	13-Oct	Family Members	St Basil's
23	13-Oct	Family Members	St Basil's
24	13-Oct	Family Members	St Basil's
25	14-Oct	Advocacy CEOs & Advocates	OPAN and ERA
26	14-Oct	Case Lead	Department of Health
27	14-Oct	Chief Nursing Officer	Austin Health
28	15-Oct	Pathology Collection	Melbourne Pathology
29	16-Oct	Family Members	St Basil's
30	16-Oct	Family Members	Epping Gardens
31	16-Oct	Surge Workforce	Epworth Healthcare
32	16-Oct	Residential Care In-Reach Team	Northern Health
33	20-Oct	Management Team	Epping Gardens
34	20-Oct	Infectious Diseases	Northern Health
35	20-Oct	Deputy Secretary	DHHS Victoria
36	21-Oct	Chief Health Officer & Public Health Unit	DHHS Victoria
37	21-Oct	Aged Care	DHHS Victoria
38	22-Oct	Surge Workforce	DHHS Victoria
39	23-Oct	Adviser	St Basil's
40	23-Oct	Emergency Operations	Ambulance Victoria
41	23-Oct	Family Members	St Basil's
42	27-Oct	Residents	Epping Gardens
43	27-Oct	Chief Executive Officer	Heritage Care
44	28-Oct	Management Team	Epping Gardens
45	29-Oct	Resident	Epping Gardens
46	29-Oct	Support Office	Heritage Care
47	30-Oct	Act First Assistant Secretary	Department of Health
48	5-Nov	Commissioner and Staff	Commissioner for Senior Victorians
49	6-Nov	Human Resources	Heritage Care
50	17-Nov	Managing Director	Heritage Care