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RESEARCH ARTICLE

Implementing recommended COVID-19 public health measures in the era of living with COVID-19: Experiences of residential aged care facility managers in New South Wales, Australia

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Abstract

Objectives: To understand residential aged care facility (the facility) managers' perspectives on implementing public health measures (the measures) in their facilities in terms of barriers, facilitators and suggestions for improvement, after three years of the COVID-19 pandemic.

Methods: Nine managers of the facilities without an active COVID-19 outbreak across New South Wales, Australia, representing metropolitan and rural locations, diverse facility size and star quality rating were interviewed (April–June 2023) and data qualitatively analysed.

Results: Broader policy context, the need to balance the measures with resident well-being, facility-built infrastructure and mask fatigue were reported as barriers to implementation. Workplace policies, cultural embedding and local innovations were reported as facilitators. Suggested strategies included recommending the measures consistent with temporal COVID-19 risk; government agencies improving communication about the measures; mandatory staff vaccination; and simplified reporting requirements.

Conclusions: We recommend that relevant government agencies develop a single source of formalised, endorsed, up-to-date advice for the sector-specific COVID-19 information and communications; streamline outbreak notification and reporting requirements; and improve consultation with the sector.

KEYWORDS

COVID-19, outbreak, public health, residential facility

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1 | INTRODUCTION

In Australia, there were almost eleven and a half million confirmed cases of COVID-19 and over 21,300 COVID-19-associated deaths between January 2020 and June 2023.[1] The impact of COVID-19 in Australia has disproportionately affected older adults,[1] especially people living in residential aged care facilities (the facilities).[2–5] The reasons for the increased risk of COVID-19 mortality in this setting is multifaceted but includes this population being older, having other risk factors for severe disease and/or facility and environmental factors such as communal and shared living arrangements.[3–6]

In Australia, states and territories are legally responsible for public health protection, including the management of disease outbreaks.[7] The implementation of public health measures (the measures), including regulations related to COVID-19 vaccination, entry restrictions, mask use, social distancing, ventilation and outbreak control responses, has been central strategies for reducing the impact of COVID-19 outbreaks in the facilities in Australia.[5,8–10] However, a Royal Commission into Aged Care Quality and Safety[11] highlighted weaknesses in the Australian residential aged-care sector's response to the pandemic, including the failure to meet the social and emotional needs of residents and families vis-a-vis stringent and prolonged measures, and poor infection prevention and control practices.[7,11]

Two studies conducted in regional New South Wales (NSW), Australia, early in the COVID-19 pandemic response,[12,13] considered the residential aged care facilities' managers', staff, families' and residents' perspectives on the impacts of protective measures in the facilities. Since then, however, COVID-19 epidemiology and pandemic response settings in Australia have considerably changed, including the following: widespread community transmission with numerous waves driven by different COVID-19 variants/sub-variants[1,7]; frequent and widespread COVID-19 outbreaks in the facilities[2]; the community-wide roll-out of COVID-19 vaccines (with a focus on the residential aged care facility residents)[14]; increased availability of COVID-19 antivirals[14]; and COVID-19 public health and social measures in the facilities no longer mandated (The last Public Health Order in NSW ended on 30/11/22).[15]

Residential aged care facility COVID-19 outbreak guidance has also adapted in response to evolving evidence, epidemiology and risk.[9,10,14] Strict outbreak management measures have generally shifted to more nuanced public health recommendations and advice.[10,13,14,16] The Public Health Unit (PHU) role in NSW is now advisory in outbreak response, while the outbreak lead role has shifted to the facility managers.[10,16,17]

While some global literature reports on nursing home leaders' views on COVID-19 outbreak management,[18–21] little is known about Australian residential aged care facilities managers' experiences of implementing the now recommended measures within this changing context. As we transition to living with COVID-19, there is a pressing need to understand how to support the facilities and the facility managers in Australia to keep residents COVID-19 safe while balancing residents' and families' social and emotional needs.

Policy impact

After three years of the COVID-19 pandemic, managers of residential aged care facilities in New South Wales, Australia, reported difficulties implementing public health measures. Relevant government agencies should develop a single source of up-to-date residential aged care facility COVID-19 advice and information; streamline outbreak notification and reporting; and improve consultation with the sector.

In the light of the above, the aim of this study was to document the barriers and facilitators experienced by managers in implementing the now recommended measures in the facilities in the Hunter New England area of NSW, the largest of the six Australian states. In addition, the study explored managers' suggested improvements for implementing the measures in the facilities over the course of a dynamically changing pandemic.

2 | METHODS

A qualitative methodology was considered most appropriate to capture managers' experiences and document barriers and facilitators to implementing the measures. This study received approval from the University of Newcastle Human Research Ethics Committee, protocol number H-2023-0041.

We invited 19 facilities from a possible 123 facilities (March–April 2023) and aimed to recruit 8–10 of them using maximum variation sampling to ensure diversity in locations (rural and metropolitan—determined by the Rural, Remote and Metropolitan area health workforce classification[22]), resident numbers in facilities, the level of overarching governance, the number of outbreaks the facility had experienced and the independent service quality measure (determined by an Australian Government Star rating system regulated by the Australian Government[23]; File S1). Only the facilities that had experienced a COVID-19 outbreak in the previous 6 months were invited to participate. Facilities

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with an active COVID-19 outbreak at the time of the study were ineligible to participate.

Invitations to participate in the study were emailed by MV, a nurse consultant well known to facility managers due to her role in the Hunter New England District COVID-19 response. That email included an overview of the project, a participant information statement and an authority to provide facility consent form. If facility consent was received, managers were invited to participate in an interview and encouraged to contact the research lead (KT) directly with questions. Managers who sent their individual signed consents were then contacted by KB who scheduled an interview and provided participants with a list of measures that were intended for discussion at the time of the interview (Table 1). Participants were asked to start considering which measures from the list had been easy or challenging to implement in their facility, and whether there were some that had not been implemented.

An interview guide (File S2) was developed by the research team, composed of public health clinicians (DD, PM), a nurse consultant (MV) and social scientists (KB and KT), and pilot-tested among PHU nurse consultants. The guide was designed to (i) elicit managers' perceptions of how easy or difficult it had been to implement the recommended measures, (ii) ascertain which measures had not been implemented, and why; and (iii) elicit facilitators to measure implementation and suggestions for improvement.

Given the high risk of a COVID-19 outbreak in the facilities at the time of the interviews (April–June 2023), all interviews were conducted using Microsoft Teams online conferencing. Interviews were conducted by a female experienced public health social scientist (KB) who, at the start of each interview, stated her affiliation and reasons for conducting the research. Only KB and the participant were present at each interview. Interviews ranged from 45 to 73 min and were not repeated. After each interview, a gift basket was sent to managers as a gesture of thanks.

2.1 | Analysis

Audio recordings of interviews were transcribed verbatim using the otter.ai transcription software. Text was subject to the three steps common to most qualitative data analysis: immersion, coding and categorisation.[24] In the immersion stage, transcriptions were proofread against the audio by one researcher (either KB or KT). In the coding stage, each transcript was read by a researcher (either KB or KT). Codes were identified inductively to succinctly capture managers' experiences and suggestions and recorded together with the relevant transcript excerpts in a bespoke data analysis table created in Microsoft Word. In the categorisation stage, barriers and enablers reported for each public health measure were categorised at the group level (residents, visitors, staff and managers) and further aggregated into six factors common to all groups that were reported to make measures difficult to implement (e.g., barriers), easy to implement (e.g., facilitators) or were

TABLE 1 List of Public Health Measures (PHMs) provided to managers prior to, and referred to, at interviews.

Residents
1. Stay in their room when they had runny nose, sore throat, cough, fever
2. Stay in the facility (i.e., could not go out, could not go to see their family)
3. Wear a mask for up to 10 days after testing positive to COVID
4. Wear a mask in public areas outside the facility
5. Stay up to date with vaccinations/boosters for COVID/Flu. (e.g., Have had/will have a COVID/flu booster this year)
Visitors
1. NOT enter a RACF if have symptoms of COVID – or have been in close contact with a person who has COVID, or have tested positive to COVID-19 in the last 7 days
2. Be up to date for all vaccinations including COVID and influenza. (e.g., Have had/will have a COVID/flu booster this year)
3. Hold visits outdoors or in well-ventilated areas away from other residents
4. Wear a mask. However, masks can be removed for example, while communicating with another person who is deaf or hard of hearing
5. Maintain a physical distance of 1.5 m, particularly in communal areas
Staff
1. Take meal breaks in areas with good natural ventilation or outdoors
2. Not enter an RACF for at least 7 days after a positive test, or if been in close contact with a person who has COVID-19, or if have any acute respiratory or influenza-like symptoms
3. Undergo a COVID-19 RAT (rapid antigen test) at least every 3 days
4. Wear a surgical mask covering nose and mouth while indoors in the facility
5. If mask removed—remain 1.5 m from others, particularly in indoor communal areas (except re: noted reasons for removing a mask, see overleaf)
6. Stay up to date with all vaccinations/boosters including COVID-19 and influenza. (e.g., Have had/will have a COVID/flu booster this year)
Managers
1. Use natural ventilation wherever possible
2. Seek professional advice from an occupational hygienist or ventilation engineer

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TABLE 2 Participant characteristics.

Facility number	Manager number	Stand-alone (not part of a larger corporation)/ Corporate (part of a larger corporation)	Number of beds	Facility Star rating (1–5)[a]	Metropolitan/ Rural[b]	Years managing at this facility
F1	M1	Stand-alone	141	5	Metropolitan	29
F2	M3	Corporate	121	3	Rural	5
F3	M2	Stand-alone	108	2	Rural	2
F4	M4	Corporate	99	4	Rural	1
F5	M5	Corporate	40	5	Rural	2
F6	M6	Stand-alone	26	5	Rural	
F7	M7	Corporate	84	3	Metropolitan	12
F8	M4	Corporate	120	4	Rural	4
F9	M8	Corporate	223	4	Rural	4
F10	M9	Stand-alone	85	3	Metropolitan	2

[a]Star Ratings for residential services | Aged Care Quality and Safety Commission.

[b]The Rural, Remote and Metropolitan Area (RRMA) healthcare workforce classification, available from: Rural, Remote and Metropolitan Area | Australian Government Department of Health and Aged Care.

bidirectional (could be a barrier or facilitator depending on the circumstances). The strategies suggested by managers were categorised into three groups. Codes and categories were distributed to all authors throughout the data analysis process, which was undertaken iteratively, concurrent with interviews being conducted. All authors were involved in considering the coding and categorisation undertaken by KB and KT. Any disagreement was resolved by consensus among two or more authors. Saturation of codes and categories was reached at six interviews.

3 | RESULTS

3.1 | Participants

Nine facility managers representing 10 facilities participated in the study. Some invitations went unanswered, one reported no time to participate and three were referred to regional managers or in-house research governance teams and went unanswered. Of the nine managers who participated, eight were Registered Nurses. The experience managing the facilities ranged from 1 to 29 years (Table 2). Six facilities were part of a larger corporation while four were stand-alone, three were metropolitan and seven rural. All had dedicated dementia specific areas (Table 2).

3.2 | Barriers and facilitators

Below, we summarise six factors discussed by managers that were described as either barriers to implementing the measures in the facility: (1) lack of mandates; (2) resident well-being; (3) mask fatigue; facilitators; (4) workplace policies, norms and innovations; or bi-directional; (5) facility-built infrastructure; and (6) individual motivations. Selected de-identified quotations are included in Table 3 to illustrate key points.

3.2.1 | Barriers

Lack of mandate

Across all measures, managers reported difficulty introducing voluntary measures compared to when the measures were mandated by public health legislative orders, thereby giving managers 'backup to say...we're not doing this, this is what the health advice is' (M3). Some expressed concerns about and experiences of pushback or verbal attack from visitors, or threats to report the facility to authorities on the basis of resident and family rights (Table 3).

Resident well-being

In addition to the impact of COVID-19 on residents' physical health, managers reflected on the impact of certain recommended measures on residents' psychosocial health, especially for residents who experienced cognitive decline, dementia or were non-verbal. Measures such as in-room isolation, social distancing and mask-wearing (residents, visitors and staff) when indoors were often described as impractical. Managers also acknowledged the impacts of a lack of social interactions for residents that resulted from strict adherence to some measures. The social and emotional benefits (such as close contact; seeing

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TABLE 3 Selected participant quotes.

Key finding	Participant quote
Barriers	
Lack of mandate	*Even though the PHU are recommending it, if the visitors complain about it, that's really my decision. I find that difficult... Because, to say no, to these people. You know, I mean, you start residents' rights and, and family rights*. (M9) *It leaves itself open to interpretation between must and should or recommended. It's hard to hold the line when something is recommended*. (M3)
Resident wellbeing	*Because the resident...they don't understand the concept of why they've got to wear a mask, you know, often they don't even understand the concept of COVID, or what COVID is, or even why they've got to stay in their room*. (M7) *... eating is a very social event, for a lot of people, you know, so you tend to find that they eat less, when they're not around other people. So that in itself then brings on other contributing health factors to them, you know, you get weight loss, you get increased risk of falls from the weight loss, because they become weaker*. (M4)
Mask fatigue	*... It's day in day out weeks, months...So, I find that they were getting very tired, fatigued, bit stressed*. (M9)
Facilitators	
Workplace policies, norms and innovations	*They [staff] are compliant, because that's one of our policies to work here. They have to keep up with their flu vaccination, and they need to have at least three of the COVID vaccinations*. (M2) *That's why they stick to the daily tests, because they don't want to go back into wearing the gown and the screen, and the mask and the gloves and all that stuff... So, they're very particular in hand washing and wiping the handrails and then they realise that the reason behind doing all these things is to prevent extra work for them*. (M6) *... we have activity packs that residents can do on their own. It doesn't take away that isolation, but it certainly helps support it*. (M3) *I moved down the tearoom... we bought a smaller table; we arranged the staffing so that only two people could go to lunch together in the tea room so that it was less exposure*. (M6)
Individual motivations	*So, residents are much, much more accepting. It's like, okay, I've had an exposure, I've been exposed to someone, I'll stay in my room, I might not like it, but I will do the right thing. For the benefit of everyone else*. (M3) *If a resident has the cognitive ability... they'll stay in their room, they want to do the right thing. The resident wants to well "I'm unwell. It's unfortunate. I have COVID I'll stay in my room. I'd hate for someone else to get sick"*. (M3)
Suggested strategies for improvement	
Making it easier for RACF managers to implement PHMs	*If there was a letter sent out to us, so we could send it on to the families... We need a letter to say this is coming from the public health unit or the government or the Commonwealth somewhere to say, look, it's not us enforcing this, but we will enforce it to the best of our ability*. (M2) *I think just the social distancing, that, you know, I think we should drop that, like I said, this is, this is their home...As long as we're promoting hand hygiene*. (M8) *I just think there's fatigue around it [mask wearing]. So, I think we need to let it go. So, we can bring back the importance when we are at high risk, and actually in an outbreak*. (M5) *I think it should be...mandated for people who are working with vulnerable people...I just feel that it's a responsibility that you had that is part of the job...And it is way, the government says you have to do it, then it's way easier to get them done*. (M9)
Improving communication with the Commonwealth and PHUs about PHMs	*I think this should have just been one link at the top of that page, you know, should have had latest advice, because oh crikey, you had to click into New South Wales...so many different options, too many options, too busy*. (M8) *What would make it easier for me and other managers would be: consult with us*. (M5) *Because they asked you all these questions, and... they made you feel really incompetent. Whereas we know our business, you know, how to run our business, they don't*. (M7)

(Continues)

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TABLE 3 (Continued)

Key finding	Participant quote
Improving outbreak management processes	*There was one day during the pandemic...I spent seven and a half hours solid in meetings, outbreak management meetings with the PHU, the Commonwealth, doing line lists [reporting requirements], the whole lot, seven and a half hours and I said to them, that's seven and a half hours that I can't be out on the floor, making sure that the staff are wearing correct PPE, that we're doing hand washing, that we've got correct hand sanitizer*. (M4) *I think with the Public Health Unit locally, the fact that you can't pick up a phone and ring someone is problematic*. (M1) *I've found frustrating...the inconsistency when it comes to the line list, the expectation around the line lists. So, I think it, you know, it's 2023 and we're still using Excel spreadsheet to calculate who's positive, who's negative, how many cases there are, there's not a live data, so to speak, you know. From a Commonwealth perspective there is, there's a portal that you enter stuff directly into; but from a state perspective, there's not*. (M4) *You get a phone call from the Commonwealth, and ... more or less, you know, 'Hi, oh, I believe you got an outbreak? Is there anything we can do?' And I mean, that's really sweet. But I mean, they don't really do anything*. (M9)

TABLE 4 Examples of innovations in RACFs, to facilitate Public Health Measure (PHM) adoption.

Group	Examples
Residents	• Offering alternatives to self-isolation for residents living with dementia (e.g., offering patients living with dementia to mobilise free of restraint public areas if they are shadowed by someone sanitising surfaces; allowing COVID-19 positive residents to mix with each other) • Strategies designed to make self-isolation when symptomatic less emotionally burdensome (e.g. facility organising activities for residents during self-isolation; having dedicated lifestyle team members and nominated visitors for the isolating resident)
Visitors	• Installing screening tool/ checklist of symptoms at entry; allowing visitors to bring their RAT results as opposed to testing at entry; and extending visiting hours over the weekend
Staff	• Providing free RATs; offering vaccinations onsite; offering permanent employment to ensure staff have sick leave when testing positive with COVID-19; approving different types of leave to help people receive pay once their sick leave entitlements were all used; and rearranging staff lunch areas to facilitate social distancing

facial expression and smile; feeling cared for) of not adhering to these measures were often described as outweighing risks of COVID-19 transmission.

Mask fatigue

Across all recommended measures, managers reported that staff struggled the most with wearing masks while indoors. Managers described masks as being hot and uncomfortable, especially during the physical work of cooking, cleaning or helping residents with showering. Masks were also described as 'just another layer of challenge' (M8) when communicating with residents living with dementia.

Managers commented that after 3 years of COVID-19 pandemic, there was substantial mask fatigue among staff, which contributed to lapses in mask-wearing. Some expressed concern that mask fatigue could also contribute to personal protective equipment being worn incorrectly during outbreaks.

3.2.2 | Facilitators

Workplace policies, norms and innovations

Without a supportive legal mandate, some managers decided to enforce selected recommended measures by writing them into the facility's policies as conditions of entry and employment. Examples included being up to date on the annual influenza and three doses of COVID-19 vaccinations.

Participants shared how they built a work-place norm of using measures. For example, some managers framed the measures in terms of social norms and workplace safety. One manager conveyed to staff that routine rapid antigen tests (RATs), wearing masks and staying up to date with vaccinations were a way of caring for themselves and reducing future work by preventing COVID-19 outbreaks. Managers also spoke about the process of normalisation of the measures among visitors and staff over time. For example, some noted that families who had been

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with the facility through the pandemic were more accepting of the measures than those who joined the facility in recent months.

Some managers described making concerted efforts to innovate or adapt facility processes and built infrastructure, to make adherence to the measures easier for residents, visitors and staff (Table 4). These included strategies designed to make self-isolation when symptomatic less emotionally burdensome, using screening tools or symptom checklists at entry, or offering permanent employment to ensure staff could take sick leave when testing positive with COVID-19.

3.2.3 | Bidirectional (facilitator and/or barrier)

Facility built infrastructure

All managers commented on the challenge of implementing certain measures within existing built infrastructure. For example, some managers noted that physical distancing was very difficult in facilities with shared bedrooms and limited indoor spaces, where COVID-19-positive and -negative residents needed to isolate together. Most noted was the difficulty of keeping spaces well-ventilated in facilities that were older and not purpose-built for outbreak management. Limited outdoor spaces and lack of shelter meant that residents, staff and visitors could not hold meetings outside, nor could staff take meals outdoors (especially during inclement weather). Conversely, having large indoor and outdoor spaces, gardens, balconies and the ability to open windows were all described as enablers for good ventilation, room isolation when symptomatic, and social distancing.

Individual motivations

Some managers reported COVID-19 vaccine hesitancy among visitors and staff, and some ideological opposition to vaccination in general. Whilst vaccine hesitancy or refusal was not the focus of this study, it is important to note that these were reported by managers as barriers to vaccine uptake among the older residents, especially where resident vaccination was opposed by families.

Managers reflected on residents', visitors' and staff's altruistic motives (to protect others) as helpful in adopting the measures. For example, managers described how many residents who were able to understand COVID-19 wanted to keep other residents safe, and were therefore willing to adopt the recommended measures.

3.3 | Suggestions for improvement

Managers suggested various ways in which the implementation of the measures in the facilities could be improved during pandemics. These were categorised according to: (1) implementing the measures; (2) communication with the Commonwealth and PHUs about the measures; and (3) outbreak management.

3.3.1 | Making it easier for the facility managers to implement the measures

Managers suggested that receiving and being able to share an official letter from the PHU listing recommended measures with families and staff, would give more legitimacy to the facility's requirements and policies to potentially reduce the currently experienced backlash.

Some managers suggested that certain measures should not be recommended or enforced in future pandemics. These included resident in-room isolation, social distancing and mask-wearing inside the facility for residents, visitors and staff, which were described as barriers to communication and the psychosocial well-being of residents. Instead, staff and visitors being up to date on vaccination, staying away with any respiratory symptoms and using good hand hygiene were recommended. Similarly, given mask fatigue, some managers recommended reserving masks and other personal protective equipment wear for influenza seasons and outbreaks of respiratory illness.

On the other hand, some managers thought certain measures should be mandated. With the reported decrease in influenza vaccination among staff in the previous 2 years when such vaccination was not mandated, managers recommended mandating seasonal influenza and COVID-19 vaccinations for the staff.

Above all, many managers commented that the aged care sector was in crisis and needed to be better supported in general and during pandemics and outbreaks in particular. Their recommendations included the introduction of sector-wide policies and funding to address workforce issues, sick leave for staff and extra resources to help facilities meet the costs of pandemic-related infection control.

3.3.2 | Improving communication with the Commonwealth and PHUs about the measures

Managers called for timely updates about COVID-19, including changes in COVID-19 advice, vaccine schedules and the measures. These updates should be timely and easily accessible to managers from a relevant website, specific to the residential aged care sector and written in a way that is concise and clear.

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Managers also called for clarity in recommendations. They found ambiguous language in the measures (on whether measures were mandatory or recommended) unhelpful.

Many wished that the government had consulted with them specifically about the measures, regulations and quality standards. They suggested this would be helpful in ensuring that the measures make sense and are realistic and practical for the facilities, and appropriate for residents. Being treated as experts in the aged care sector, with one's knowledge and expertise valued, could facilitate a consultative approach.

3.3.3 | Improving outbreak management processes

Generally, managers spoke highly of the support they received from PHUs during outbreaks, referring to professionalism and friendliness. Managers recommended, however, eliminating repetitive demands for reporting to different agencies (Commonwealth, PHU and others) to minimise staff distraction and burnout.

Many desired access to a 'real person' who they could ask for advice when needed (as opposed to an 1800 number, or a generic email with delayed response times). They suggested a manager support line staffed by people familiar with the specific facility who could provide tailored advice 'on the spot'.

Many also wished that the reporting system (e.g., line lists) were automated and compatible at the Commonwealth and PHU levels.

Finally, some managers noted that despite the Commonwealth inviting requests for help during outbreaks, managers did not receive what they requested. This contributed to the perception held by some managers that offers of support from the Commonwealth were tokenistic.

4 | DISCUSSION

We explored experiences and opinions of the residential aged care facility managers in NSW about implementing the public health measures in their facility in a context of relaxing COVID-19 public health and social measures, with particular focus on barriers, facilitators and suggestions for improvement.

4.1 | Implementing the measures

Earlier work has identified that facility managers and leaders have been required to innovate and deploy new strategies to implement the measures in their facilities.[12,19–21] Our work builds on this, finding managers demonstrated flexibility and adaptability in implementing the measures that are tailored to their facility's unique circumstances (such as built infrastructure) and the needs of residents and families.

Previous work (including formal reviews of the NSW Health COVID-19 response) has highlighted the difficulties staff and managers faced keeping abreast of rapidly evolving public health advice from different agencies during the COVID-19 pandemic.[10,18,20,25,26] Several managers in the current study reported this challenge, and recommended communications channels should be improved to ensure information and communication is sector-specific, readily accessible and clear. This recommendation is aligned with the findings of the 'Independent Review: COVID-19 outbreaks in Australian Residential Aged Care Facilities', which recommended an up-to-date 'single source of truth' for COVID-19 information for the sector.[9]

Our findings further reinforced the importance of and need for greater consultation with the residential aged care facility stakeholders (including consumers) in public health and emergency planning in the aged care sector.[9,13] Participants emphasised their unique expertise in this sector and how their perspectives could ensure more realistic and achievable strategies to manage the risk of COVID-19 in the facilities. Reflecting the importance of sector consultation in informing public health advice, recent revisions to the national Australia Residential Aged Care Facility outbreak control guidance has been developed in consultation with the aged care sector.[8]

4.2 | Balancing the risks and benefits of public health measures

Many participants were aware of the potential health impacts of COVID-19 on residents and the importance the measures play in reducing COVID-19 transmission in the facilities, but also highlighted the negative impacts of some measures on resident well-being. Managers' concerns that the measures, particularly isolation and visitor restrictions, can negatively impact on residents' well-being have been well-described in the literature.[27–29] Indeed, the need for a proportionate and human rights-focussed approach to COVID-19 outbreak prevention and control has led to revisions in outbreak control guidance in the residential aged care facilities in Australia and NSW.[8,10,14,16] Major changes in the NSW guidance over time have included: reduced resident isolation and quarantine periods, explicit support for visitation during an active outbreak (with risk mitigation measures) and a greater focus on resident choice regarding isolation.[10,16]

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4.3 | Limitations

All residential aged care facilities differ in the composition of their residents, built environment and resourcing. In acknowledgment of these important differences, we purposively selected a diverse range of facilities. The focus of this study was the current situation and future looking. However, the findings could have been influenced by the varied past experiences of our participants. Participants' period in the role could well have influenced their perspective but this was not explicitly explored.

We acknowledge the potential for reporting bias: that responding participants may have had different experiences to non-responders. As with all qualitative methodology, our results represent the views of participating individuals and the facilities and are not generalisable. However, we believe many concepts may be more broadly applicable.

5 | CONCLUSIONS

This study was conducted in an environment where strict public health measures that were mandated in the early stages of the pandemic had generally shifted to more nuanced public health recommendations and advice. The approach to managing COVID-19 outbreaks has likewise transitioned to standardised public health guidance. Despite the public narrative of living with COVID-19 as the 'new normal', most managers expressed concern about the ongoing risks of COVID-19 for the residents. While managers perceived some measures as helpful in protecting the lives and well-being of the residents and suggested some be made mandatory, they simultaneously suggested that some other measures should be removed (see 'Suggestions for improvement' section in Results). Many spoke of the complex factors influencing implementation of the measures in their facility (including broader policy context; the need to balance the measures with resident well-being; facility-built infrastructure and mask fatigue). Participants provided examples of workplace policies, norms and innovations they have implemented in their facility to facilitate the adoption of recommended measures Informed by the experiences documented in this study, we recommend that:

- a single source of formalised, endorsed up-to-date advice for the residential aged care facility COVID-19 information and communications is developed by relevant government agencies;
- a phone line to provide managers with real-time guidance on specific questions is implemented;
- notification and reporting requirements when a facility has a COVID-19 outbreak are streamlined and standardised across relevant government agencies; and
- there is early and genuine sector consultation during future outbreak guidance review.

As we transition into living with COVID-19, developing public policies informed by the facility managers' perspectives and suggestions could help to better protect the residential aged care facility population. This could also help to ensure that the managers and staff are better supported in their critical roles.

We recommend that future qualitative research similarly explores the perspectives of other residential aged care facility stakeholders (residents, families and staff) on incorporating the measures into their daily routines. This study has also identified the need to better understand the psycho-social impacts of managing the facility within the changing COVID-19 social and policy context on the facility managers.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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