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The Long Term Care COVID-19 Situation in Malaysia

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1. Key points

- Malaysia has ten (10) federal-funded old folks' homes and two (2) homes for the chronically ill in Peninsular Malaysia, five (5) state-funded old folks' homes in East Malaysia, and a number of Islamic care homes operated and/or supported by State religious authorities.
- There are about 320 residential aged care facilities registered under the Department of Social Welfare (Act 506) and 26 nursing homes registered under the Ministry of Health (Act 586). The number of unregistered facilities numbers from 700 to over 1000, depending on estimation method and definition used.
- Community and home-based long-term care are currently unregulated in Malaysia.
- Department of Social Welfare and Ministry of Health officials work closely with academics, care home representatives and civil society groups to reach out to aged care providers.
- Malaysia has adopted a mass-testing strategy for all registered and unregistered care homes. As of 25 of May, testing involving 10,890 staff and residents from 267 facilities, of whom 9,122 (83.8%) were tested, yielded a positivity rate of 0.2%. A majority of those tested positive were asymptomatic (85.7%).
- Previously, two older persons clusters have been reported (and closed) which involved at least two aged care premises in Klang and Petaling Jaya, resulting in 36 infection and five (5) deaths.
- Care homes lack basic PPE and have difficulty observing physical distancing within their confined spaces.
- The industry body proposed a 'No visitors' policy and care homes are discouraged from admitting any new residents
- Care home residents with suspected COVID-19 will be admitted to COVID hospitals, with all other residents admitted for isolation and testing if necessary.
- The Ministry of Health have also recently mandated that older persons to be discharged to an aged care facility to be tested for COVID-19.

2. Introduction

This is a preliminary report on the impact of COVID-19 on vulnerable older Malaysians residing in long term care facilities (LTCF) such as Care Homes (CH) and/or Nursing Homes (NH). This provides an overview of key events and measures introduced at the national level, and responses by key / relevant stakeholders as well as Non-Governmental Organisations (NGOs). In Malaysia, the very first case of COVID-19 (imported) was reported on 24th January 2020 involving three Chinese tourists who entered Malaysia via Johor. On March 11th, Malaysia then confirmed its first sporadic case of Covid-19 in the community [1].

Based on the population clock at the time of reporting, Malaysia's population stand at 32,760,472 [2]. As of July 2019, it was estimated that the share of the Malaysian population aged 65 years or over stood at 6.7 percent. The National Policy for Older Persons (2011) defines an older person as an individual aged 60 years or over. Malaysia is currently facing the prospect of a rapidly ageing population, and the latest statistical data predicted this to be happening as soon as in 2030 [3]. With this pandemic largely affecting the vulnerable groups – older persons and those with chronic medical conditions, this report is indeed timely.

The Crisis Preparedness and Response Centre (CPRC) which was established under the 9th Malaysia Plan (2005 – 2010) as part of the overall strategies in preparedness of effective management of disasters, outbreaks, crises and emergencies related to health has played a vital role in the coordination of care and dissemination of information to the relevant stake holders as well as public [4]. The CPRC is placed under the Surveillance Section of the Disease Control Division, Ministry of Health Malaysia. During this current COVID-19 pandemic, CPRC has been operating 24 hours a day for the last 4 months, anticipating the worst while taking major steps to “flatten the curve”.

The Director General of Health provides a daily press conference which is live streamed on social media at 5.00pm (GMT+8). Daily reports of confirmed new cases, number of deaths if any and total number of discharges from recover is provided during this press conference. Details of all deaths are provided at this briefing together with the clusters the new cases are linked to. Updates of new cases in active clusters are also provided [5].

3. Impact of COVID19 on long-term care users and staff so far

3.1. Number of positive cases in population and deaths

As of 30 May 2020, there was a total of 7,762 confirmed cases of SARS-CoV-2 infection in Malaysia, with a total of 115 deaths (1.41%). The number of active cases have been falling since mid-April and only 1,351 are still under treatment. Please refer to Figure 1 for the number of cumulative and daily cases, recoveries and deaths.

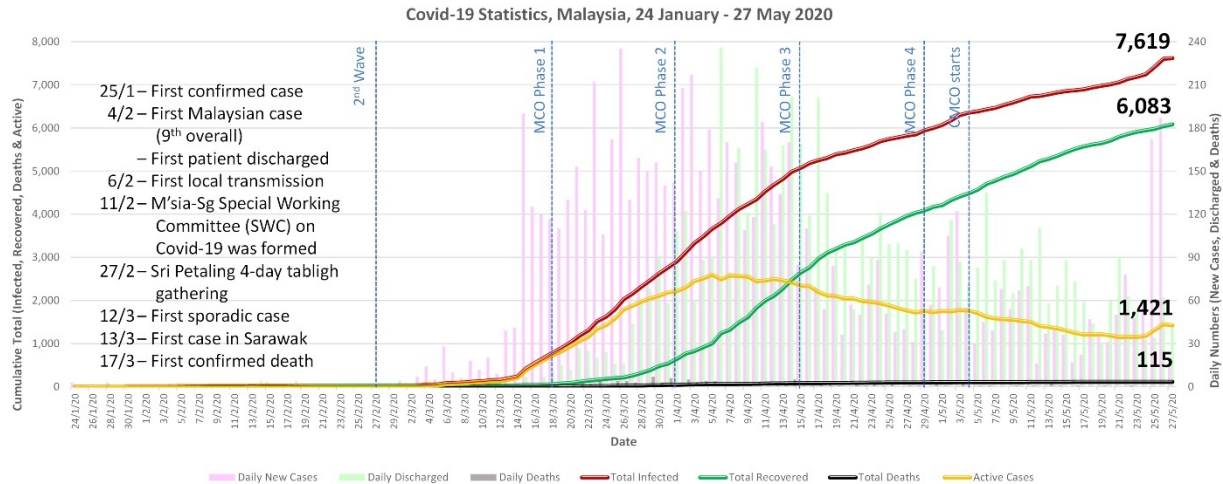


Figure 1. COVID-19 Statistics, Malaysia, 24 January – 27 May 2020

Source: MyAgeing, UPM

3.2. Rates of infection and mortality among long-term care users and staff

The exact number of affected long-term care users and staff is unknown as details of the outbreak known to the authors at the time this report was produced has been withheld due to concerns about medicolegal implications. The Ministry of Health of Malaysia has reported an Older Person Cluster (Kluster Warga Emas) with Care Centres that resulted in 36 infected individuals and five (5) deaths, located within the Petaling and Klang districts in the state of Selangor [6]. It has not been officially revealed whether all 36 affected individuals were actually care home residents or staff. Informal, unconfirmed sources suggested that two (2) of the cases who died were from a single care home, and three (3) death were from care home residents. Five (5) members of staff and three (3) other residents also tested positive from the same facility. The source of infection was from the discharge of a resident from hospital. The other confirmed cases and deaths within the cluster are therefore likely to be patients and staff from the hospital outbreak and their close contacts. All five (5) deaths from that single cluster were of older adults we were frail with multiple comorbidities. No other clusters involving care homes has been reported by the Ministry of Health.

Screening activities started on 4 May 2020. As of 30 May 2020, a total of 11,049 residents and staff has been screened from a total of 295 care homes that found 26 positive cases. The number of care homes affected has not been reported since 20 May 2020 when it was announced that the 18 positive cases at that point was from 15 care homes, indicating COVID-19 was present in 8% of care homes [7]. Out of the 26 cases, 22 (85%) were asymptomatic carriers [8]. As the infectivity of asymptomatic carriers are weak and the risks are debatable at this point, evidence seems to suggest much is still unknown about the spread of COVID-19 in the community. Mass screening at residential long term care facilities in Malaysia has only been planned as a once-off event, with no clear plans for future surveillance.

3.3. Population level measures to contain spread of COVID-19

Malaysia has adopted an aggressive stance toward containment of any spread of COVID-19. While self-isolation was used as a strategy for those who have travelled abroad, positive cases arising from those who returned from abroad has led to the government setting up quarantine facilities, including the repurposing of hotels for this effort. All returned citizens were swab tested on arrival at these quarantine facilities and are only discharged after negative tests on the 14th day.

All COVID-19 cases are cared for in COVID hospitals for at least up to day seven (7) of illness, after which those with mild or no symptoms are moved to makeshift hospitals and only discharged after successive negative tests. After the news of the transmission of SARS-CoV-2 at a mass gathering in a mosque in Seri Petaling, Kuala Lumpur [9], a Movement Control Order (MCO) was imposed nationwide, and has been in operation since 18 March 2020. The Movement Control Order was extended thrice on 1 April (Phase 2), 15 April (Phase 3) and 29 April (Phase 4), followed by a Conditional Movement Control Order on 4 May. Malaysia has only just started to relax lockdown rules about three weeks ago, with 80% of businesses now allowed to operate under strict Standard Operating Procedures clearly set out by the National Safety Council. All interstate travel remains prohibited. State governments, concerned about relaxation of the 'lockdown' had set their own regulations, further limiting the number of business that are able to open. Businesses have also chosen to remain shut as they struggle to comply with new SOPs, including the registration of customer / patron information at outlets. Schools, universities and businesses where social distancing are considered challenging remain shuttered [10].

The Director General of Health announced on 17 May 2020 that Malaysia has tested 420,000 individuals, and is now among the countries in Asia which has tested the most number of people. Mass testing has been conducted in hotspots, particularly areas where Enhanced Movement Control Orders (EMCO) have been enforced and vulnerable groups, including care homes and foreign workers.

4. Brief background to the long-term care system

Malaysia has 15 government-run residential homes and 2 government-run homes for the terminally ill. There are an additional 320 registered long-term care facilities in Malaysia, which at present are either registered with the Ministry of Women, Family and Community Development (or the Welfare Department) under the Care Centre Act (Act 506), or the Ministry of Health under the Private Healthcare Facilities Act (Act 586). As of this year, all long-term care facilities will be registered under the new Private Aged Care Facilities Act 2018 (Act 802) which will be enforced in 2020 by the Ministry of Health. Over 1000 long-term care facilities in Malaysia, however, remains unregistered [11]. The projected number of unregistered facilities, which ranges from 700 to 1000, depends on the estimation method used and may vary due to the lack of a clear definition and classification of aged care facilities. Applying this estimation, residential facilities serve approximately less than 1 percent of the older population, which points to the

central role of families in providing long-term care. Please refer to Figure 2 for a conceptualization of the aged care system in Malaysia.

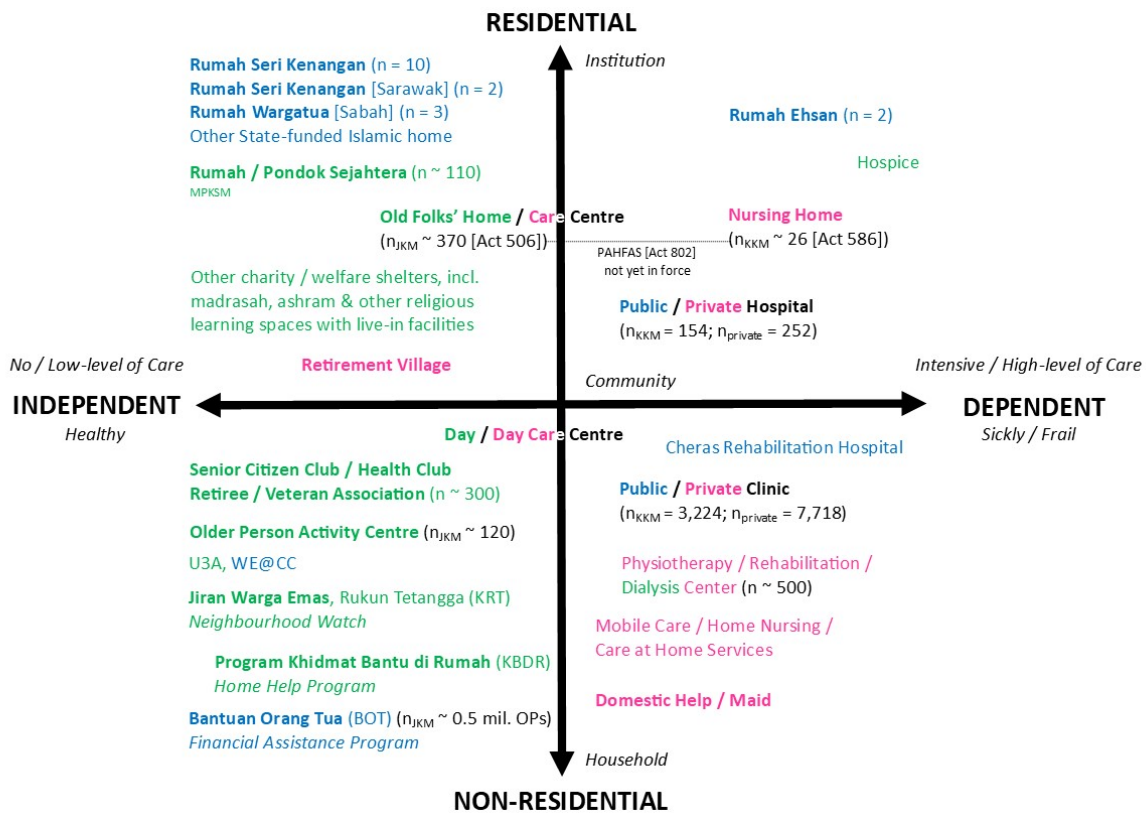


Figure 2. Aged Care System in Malaysia

Source: MyAgeing, UPM

Most long-term care facilities offer residential or nursing care, and apart from the handful of government-funded beds, are primarily operated by non-governmental organizations (NGO), religious organizations or private operators. Non-governmental organizations tend only to operate residential homes and lack the resources to care for those who require nursing-level care. Nursing homes are, therefore, primarily privately run. A handful of day-care facilities are beginning to emerge, and these are mainly privately run. Most of these residential care facilities are found in the west coast of Peninsular Malaysia, particularly in urban centres [12], which lead to accessibility and affordability issues for rural and lower income families.

Home care is usually provided by foreign domestic workers/helpers, called 'maids' who are engaged through agencies from mainly Indonesia, Philippines, Cambodia and Sri Lanka [13]. Home nursing which are usually contracted for a minimum of 8 hours a day, with many families opting for 24-hour nursing care, which is usually provided by a team for five local part-time nurses to supplement their regular income or two full-time time nurses either from Malaysia or the Philippines. The new Private Aged Care Facilities Act does not mention home-based care, which therefore remains unregulated. In addition, the Malaysian Welfare Department also introduced

a Home Help programme to assist older persons living in the community with tasks such as shopping, financial transactions or just a companionship. The volunteers receive a small cash incentive in return for two visits per month to their ward. The Malaysian Welfare Department has also received federal funding from the 11th Malaysian Plan 2016-2020 to build over 200 activity centres for older persons for each Parliamentary constituency. These Senior Citizen Centers (*Pusat Aktiviti Warga Emas*) were introduced in 2012 as it repurposed the 22 Senior Citizen Day Care Centres (*Pusat Jagaan Harian Warga Emas*) that weren't functioning as intended. As these are intended to enhance social participation rather than provide care, we have not considered these activity centres as part of the long-term care system although it has the potential for such.

Malaysia's long-term care system is fragmented, owing to the divide between health and social care as well as between public- and privately-funded care. Family members caring for an older family relative with limited physical or mental function would face difficulty in navigating the system in the search for the right level of care and means to finance it. Malaysia adopted deinstitutionalization and focused on family and community care, but the burden of care falls disproportionately on female, be it informal or formal care. The continued support by the government in hiring domestic worker as a strategy to sustain female labour productivity [14, 15] also undermines the potential growth of much needed community-based services. In addition, the gap in the types of care available between public- and privately-funded care is the impetus behind the commodification of care. The distinction between private-for-profit and private-not-for profit service providers, with issues in matching government support and/or public donations, could potentially render existing aged care operators at a disadvantage.

5. Long-term care policy and practice measures

5.1. Whole sector measures

Whole sector measures have been driven through coordinated efforts between the Association of Aged Care Operators of Malaysia (AgeCOpe), medical societies, various Ministry of Health departments, the Selangor COVID Taskforce, the Ministry of Welfare, the Malaysian Ageing Research Institute and other interested parties who developed an "Interim Recommendations for the COVID-19 Pandemic in Private, Public, and NGO Residential Aged Care Facilities" released through AgeCOpe and various informal networks primary through social media messaging on 21 March 2020 (<https://msgm.com.my/covid-19/>). The guidance is hosted on the Malaysian Society of Geriatric Medicine website in four languages (English, Malay, Chinese and Tamil), and contained a toolkit containing forms and signs in particular. It has since been revised to include guidance on discharges from hospital just three weeks later, in response to cries of financial difficulties by our care homes [16]. The Malaysian Welfare Department also provided cash disbursement to individual care homes, as part of the federal government's welfare package [17].

The adoption of these interim recommendations was announced by the Director General of Health on 16 April 2020. Subsequently, on 2 May 2020, the Director General of Health

announced that all care homes staff and residents will be tested and the initiative will include unregistered care homes as well as pondoks, as part of the country's measures to secure the safety of its most vulnerable population, as it seeks to ease lockdown measures. A guideline on "Care of Older Persons in Residential Aged Care Facilities and in the Community during COVID-19 Pandemic" was released and distributed by the Ministry of Health.

5.2. Care coordination issues

5.2.1. Hospital discharges to the community

Care of older persons discharged to the community from the hospital are mainly tasked to family caregivers who may or may not have received training by the hospital staff on how to provide care. Some older individuals were fortunate enough to have pre-existing care arrangements either from foreign domestic workers or homecare providers. However, with all travel in and out of Malaysia cancelled, it has become impossible to engage foreign domestic workers. Home care or mobile care operators are also unable to provide new services at this time due to the Movement Control Order. Mobile and community aged care services have not been explicitly listed as an essential services throughout the Movement Control Order, severely restricting the operators' ability to continue their work unimpeded. In addition, they lack personal protective equipment (PPE), and therefore many choose not to work for their own safety. No arrangements can be made for continued rehabilitation during this period.

However, the apparent absence of community care throughout the pandemic period has not deterred family members from taking their older relatives home. Many fear the potential of catching COVID-19 if their loved one remained in hospital, and the difficulty of not being able to visit due to the blanket ban on visitors have also pushed many to beg for earlier discharges.

5.2.2. Hospital discharges to residential and nursing homes

During the first three weeks of the movement control order, the interim recommendations advised against any admission to the care home including hospital discharges and direct admissions from the community. This was not sustainable, not necessarily because hospitals were becoming too full, as across the board, hospitals were not full due to a reduced number of visits to the emergency department, routine surgery was cancelled and was routine outpatients. Many care homes were struggling to pay their staff because of a reduced income due to dwindling resident numbers. Despite hospitals not being full, doctors felt a need to discharge patients as soon as possible, even to care homes, to avoid hospital acquired SARS-CoV-2 infections.

Some hospitals had refused to test older patients prior to discharge to care homes. Most homes are unable to afford enough facemasks and gloves and have little else in terms of PPEs. Few homes have isolation facilities for their residents, and as most homes are privately operated, many family members refuse to pay for the additional cost of PPEs and testing after discharge. Care home providers who are encountering cashflow issues if they did not admit new residents,

found themselves compelled to take the risk of accepting discharges. Despite fewer people coming to hospitals and routine clinics appointments and surgery cancelled during the Movement Control Order, there have been repeated reports of doctors coercing reluctant care home operators to accept discharges without testing. On 18 May 2020, the MOH made it mandatory for hospital discharges to residential and nursing home to undergo COVID-19 testing.

However, with horrifying reports from Europe and US care homes being affected by discharges who were inadvertently exposed to SARS-CoV-2 during their hospital stay, an increasing number of doctors have caved into pressure to test, and this eventually led to a blanket agreement by all Ministry of Health hospitals to test all hospital discharges to aged care facilities which was released just a week ago. Apart from the modest cash handout to care homes, which will barely fund PPEs for new admissions, there does not appear to be any effort the government to distribute PPEs to care homes. Care homes, however, have received occasional, uncoordinated donations from various sources mainly of face masks and gloves, due to increased public awareness, with the help of social media campaigns as well as mass media communications initiated by the interim recommendation group [18,19].

5.3. Care homes (including supported living, residential and nursing homes, skilled nursing facilities)

5.3.1. Prevention of COVID19 infections

The Interim Recommendation state that 'no visitors should be allowed' unless the resident is terminally ill, or under special circumstances agreed upon by the management team such as if the resident suffers dementia and exhibits severe behavioural difficulties if the family member does not attend. Contactless temperature, symptom screening, and travel and health declaration would be mandated for visitors who are actually allowed in.

In addition to the above, many care home operators were acutely aware of the potential risk of transmission in their care homes just wiping out their businesses. Their staff members willingly cooperated to their employers' request to move into the care homes and to self-quarantine the entire home throughout the Movement Control Order. The compliance of staff members was, however, likely to be encouraged by the difficulties staff members encountered in getting to work, as aged care facilities were not considered essential services during the initial phase of the lockdown. In addition, many feared employment difficulties post-MCO.

5.3.2. Controlling spread once infection is suspected or has entered a facility

Care homes operators are informed to arrange for any resident with suspected COVID-19 to be transferred to the nearest COVID hospital as soon as they are able to safely do so. While arrangements are being made, they are asked to place the older resident in a single room, or at least 2 metres away from other residents and to limit the number of staff members who provide care to one person if at all possible utilizing any PPE they are able to put together with improvisation if necessary. The care operators are also told to notify the local district health office. Both the list of addresses of COVID hospitals and contact details of local district health offices were provided to care home operators with the interim guidance, and operators were encouraged to identify the nearest COVID hospital and district health office beforehand.

With regards to the isolated recorded outbreak, contact tracing was immediately carried out and all the residents of the care home transferred to the nearest COVID hospital to be tested and isolated, since isolation was not possible in the care facility. All residents were treated as close contacts if they tested negative, and all were cared for in hospital until they have had negative swabs following 14 days' isolation.

5.3.3. Managing staff availability and wellbeing

Many care homes are dependent on foreign workers in addition to trained nurses waiting for placements under the Ministry of Health. Prior to the COVID-19 pandemic, the Ministry of Health ceased all new recruitment due to financial difficulties, and the newly qualified nurses ended up seeking employment in care homes. In addition, many senior nurses also took on senior positions as care home managers. The COVID-19 pandemic had led to the Ministry of Health summoning these freshly trained nurses, who are bonded to serve the government, immediately, leaving many care homes short staffed.

Little is known of any available measures to address staff morale and wellbeing during this stressful period, and care home operators are very much left to their own devices in this area.

5.3.4. Provision of health care and palliative care in care homes during COVID-19

Hospices have consistently declined any requests for visits to care homes even before the pandemic, therefore care homes have largely provided palliative care to their residents unsupported. Advanced care planning is generally only initiated if the care home medical director or general practitioners chooses to. Many care homes in Malaysia are operated by general practitioners. However, in most cases, advanced care planning is not provided at any point. Care home operators will call the ambulance as the first response if residents fall sick and do not tend to entertain the possibility of end of life care in the care home, with some confusing withholding treatment as euthanasia. Therefore, the use of artificial feeding through long-term nasogastric tubes is commonplace in patients with advanced dementia and other terminal conditions within care home settings [20].

Community health care for older adults is virtually non-existent, and care home residents generally face difficulties attending health clinics or GP clinics, usually resorting to the emergency

department as their first port of call [21]. There is no evidence of any change in such behaviour or the healthcare provision available to the care home resident during COVID-19.

5.4. Community-based care

No specific guidance for community-based care during COVID-19 has been developed. Day care and day centers are not allowed to operate during the MCO and despite initial positive indications, the district health offices have not provided the green light for reopening. Senior citizen clubs and activity centers also remain unopened as they are deemed recreational facilities and therefore not considered a social care priority. The home help program (KBDR) for the disabled and older persons is largely suspended as it depends on community volunteers.

As community-based care in Malaysia is still under-developed and paid largely out-of-pocket, the government does not have a comprehensive approach to its regulation. Day centers are, however, required to register under the new Private Health Aged Care Facilities and Services Act.

5.4.1. Measures to prevent spread of COVID19 infection

Home help and home visit volunteers are told to cease operations throughout the Movement Control Order. Nevertheless, demand for mobile nursing and live-in carers are still strong. Private mobile / home nursing providers are still advertising their availability throughout the COVID-19 pandemic. Due to the fear of COVID-19 transmission, home care provision is primarily provided by full-time live-in nurses or trained caregivers. As there is no regulation in this sector, some agencies have decided against mobile nursing, since PPEs cost up to four times their regular hourly rates, and few clients are willing or able to afford this additional payment. However, other agencies have elected to continue providing a service with symptom and temperature screening and just surgical masks and gloves for protection.

5.4.2. Managing staff availability and wellbeing

Since many home nursing providers are also operators of residential aged care facilities, staff out of work are advised to take leave or reassigned to other work. The Ministry of Women, Family and Community Development activated a special COVID-19 counselling hotline to provide psychological support to the public who have been impacted by the pandemic and Movement Control Order. The tele-counselling service is provided through the existing Talian Kasih 15999 and WhatsApp 019-2615999.

5.4.3. Impact on unpaid carers and measures to support them

Family caregivers are the least supported group even before the pandemic. Although Malaysia has financial assistance programmes for caregivers of bedridden family members, the number of recipients is small. As most of the cash transfer programme targets poor or lower income households, most unpaid carers receive only receive tax relief to offset healthcare costs for their parents. Support is sorely needed for family caregivers and unpaid carers in the form of respite care as well as other measures such as grocery runs, delivery of medication via post/mail, and

care training. No COVID-19 related relief measures are currently available for informal caregivers. As many care homes are not admitting, and many family members are unwilling to admit their loved ones to a care home, and home care services are also limited to premium live-in options, the burden of care on family caregivers and other forms of informal care.

5.5. Impact on people with intellectual disabilities and measures to support them

Malaysia's care homes for the disabled and cognitively impaired are regulated under the same Care Centre Act under the Department of Social Welfare. During the outbreak and subsequent Movement Control Order, the government is aware of the impact of the social distancing measures on the disabled and have relented to cooperating with NGOs in delivering aid and support to the needy. At the later phases of the MCO, more and more distribution of basic goods were affected through offices elected representatives at the local level, under the official coordination of the District Social Welfare Offices (Pejabat Kebajikan Masyarakat Daerah).

5.6. Impact on people living with dementia and measures to support them

All day care centres were told to shut throughout the MCO and to remain shut until further notice. The day care centre staff are paid by charitable bodies who have continued paying them, and therefore provide virtual support to their clients through video calls, send activities to their clients, and exercise videos. Hospital clinics which provide phone-in enquiries and walk-in services for emergencies, have regularly reported desperate calls from caregivers of older persons with dementia, and have little to offer in terms of support.

6. Lessons learnt so far

The social care policy for Malaysia has lagged behind the country's development since independence, leading to unregulated care homes and home care providers now providing the bulk of long-term care in Malaysia. Apart from the single care home outbreak leading to the loss of two lives, Malaysia's experience with care homes during COVID-19 has been surprisingly positive. Both the Social Welfare and Health sectors willingly worked with lobby groups and NGOs to protect the care home very early on the be second wave which started on 10 May 2020. The desire to 'do well' in terms of COVID-19 control and the feeling of solidary and good will that emerged during this pandemic, had led to surprisingly positive responses and support to provide for our most vulnerable population. The mini outbreak almost provided the ideal springboard to sound to alarm and sparks of a series of responses which finally led to mass testing of care home staff and residents.

While many other countries particularly Europe and North American countries struggled with unimaginable death tolls, Malaysian officials, healthcare providers and care homes watched in horror and moved to rectify any deficiencies in our system to avoid our care home becoming the source of the next wave. This crisis, therefore, perversely opened up many opportunities for

society to right many wrongs in their previous persecutory stances on care homes. Care homes prior to COVID-19 were shunned by society, received no financial subsidies from the government, whose policy it was to ensure that adult children remembered their obligation to their older parents to provide for them in their old age [19].

6.1. Short-term calls for action

With widespread testing now a reality, the next challenge is to ensure the delivery of PPEs to care homes throughout the country regardless of legal status. It remains unclear who will pay for the PPEs, which are expensive, and therefore not generally affordable to care home nor adult children to have to pay their care home bills, which average RM3000 per calendar month, whereby the average household income for Malaysian is RM6,000 per calendar month.

The interim recommendations development group through MyAgeing, UPM is expected to obtain funding from the World Health Organization to facilitate coordinated efforts to train care home staff on infection control and supply of PPEs to these facilities. There is also an effort to conduct harmonized studies to gain insights on behaviour of older adults during the COVID-19 pandemic as well as promoting greater awareness in the situation among community-living older persons.

6.2. Longer term policy implications

The Private Aged Healthcare Facilities and Services Act 2018 will be enforced in 2020, and this COVID-19 experience has more or less helped smoothen implementation, with unregistered care homes now coming forward for testing.

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ANNEX 1. Questions to support international thematic reports:

a. Data on numbers of long-term care users and staff who have had COVID-19 and number of deaths

Are any of these data available in your country?

	Residents	Staff
Numbers of tests carried out in care homes in your country	11,117	
Number of care home residents transferred to hospital due to suspected or confirmed COVID	< 10	5
Number of care home residents who died in hospital, death linked to COVID-19	3	0

Number of care home residents and staff who tested positive for COVID-19	38 residents and staff in total (26 staff and resident positive reported from mass screening, Initial outbreak 7 residents and 5 staff).	
Number of care home residents and staff who died and tested positive (before or after death) for COVID-19	3	0
Number of care home residents and staff who died from suspected/probable COVID-19	0	0
Number of excess deaths in care homes compared to same time period in previous year	NA	NA
How are care homes defined in the official mortality statistics in your country?	No	
What is the total number of people who live in care homes (as per the definition of care homes used in the official mortality data in your country) And how many staff work there?	30,000	6,000

	Service users	Staff
Number of users of community-based care (home care, day care, etc) and staff who have been tested	Unknown	Not known
Number of users and staff who have tested positive	NA	NA
Number of users and staff who have died with confirmed COVID infection	NA	NA
Number of users and staff who have died from suspected/probable COVID infection	0	0

b. Measures adopted to prevent and manage COVID-19 infections in care homes

If your country (or regions/states in your country) has adopted any of these measures, could you add some information (and ideally the date in which they were adopted)? If there are any useful examples from providers or at local level that you think would be of international interest feel free to add that as well.

Measures to support care homes in preparing and dealing with outbreaks

National task force to coordinate COVID-19 response in care homes
No formally appointed taskforce, but policy makers now participate in a WHO-funded guideline development group which has evolved from the interim recommendations group

Notification of suspected cases to Public Health authorities
The Crisis Preparedness and Response Centre

Strike forces/ Rapid response teams
NA

Reducing care home occupancy to facilitate management of potential outbreaks
<i>Care homes voluntarily stop taking in new residents</i>
<i>Short-term transfer of residents to hospital</i>

Loosening regulation and inspections
Testing offered to unregistered homes, but not financial support.

Funding to boost staff numbers: funding for additional workforce supply funding and to supplement viability of care homes
A one-off cash handout of RM8,200 (USD 2,000) was provided for all residential aged care facilities

Measures to prevent COVID-19 infections from entering a home

Isolation within facility for all residents
Infected residents are immediately moved to hospital for isolation

Measures to restrict visitors to care homes
Strictly no visitors allowed for the foreseeable future, though many are already asking how long.

Measures to reduce risk of staff passing on infections to residents
--

Care staff are advised against all trips abroad unless absolutely necessary, and those who have travelled due to unavoidable reasons are required to self-isolated for 14 days.

Care staff encouraged to move in to care homes
--

Ensuring care staff only work in one care home
--

Measures to ensure that new or returning residents do not bring in the infection

14-days' isolation encouraged after discharged from hospital
--

Care homes advised to not to take in new residents if they are able to
--

All discharges to care homes from hospitals are tested
--

Measures to monitor potential infections

Systematic symptom monitoring

Twice daily contactless temperature recording for all staff and residents. Monitoring on entry for the few visitors allowed.
--

Testing care home residents and staff
--

All care home residents and staff are currently being tested.

Training of care staff in recognizing atypical symptoms
--

Being developed by the WHO guideline development group
--

Measures to control the infection once it has entered the facility

Contact tracing and isolation based on contact

This is conducted extensively by the District Health Office

Isolation measures

Residents with COVID-19 are transferred to the nearest COVID hospital as soon as possible

All close contacts or all residents transferred to COVID hospitals for testing and isolation until 14 days clear
New admissions are isolated as much as possible, in an area separated by 2m from other residents if single rooms are not available, for 14 days.

Ensuring access to health care for residents who have COVID-19

Telehealth visits from healthcare providers
Implementation of telehealth is prohibited by the Telemedicine Act 1997 which states that those with cognitive impairment should not receive telemedicine, and all those who receive telemedicine need to first provide prior consent.

Access to palliative care
Not available (actively declined)

Advanced directives
Not available

Deploying additional healthcare staff to care homes
N/A. Staff were recalled to the health service leading to staff shortages in some facilities.

Ensuring care homes have adequate supplies of medicines & equipment
Care homes have little in the form of equipment as most things are done manually. Medicines are being delivered by government facilities and private pharmacies through a variety of methods.

Managing staff availability and wellbeing

Government (local, national or regional) takes over funding/running of care home
Not yet, but this has been considered.

Funding to boost staff numbers: retention bonus paid to staff
One of cash distribution has occurred funded by the treasury from a Department of Welfare emergency budget of RM25 million (USD 6 million).

Recruitment of additional staff
<i>Recruitment of recent graduates and health students</i>
Not done
<i>Recruitment of staff that are new to the sector</i>

Not done

Rapid response teams
Not available

Loosening staff regulations
<i>Allowing staff with restricted work visas to work more hours</i>
The staff already work 12 hour shifts, seven days a week.

Supporting care home staff with accommodation and practical measures
Care home staff are provided with accommodation by asking them to move in

Psychological support to care home staff who may have experienced traumatic situations
Not available

Measures to compensate for impact of physical distancing in care homes

Methods to combat loneliness in residents
List of activities which incorporate physical distancing provided to care homes in the interim recommendations.
Letter provided to care homes to provide to family members and close friends to explain why they should not visit, and to advise communicating through video calls and to provide instructions how to deliver food and gifts safely.