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The Long Term Care COVID-19 Situation in Malaysia

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Corrections and comments are welcome at info@Itccovid.org. This document was last updated on 21 May 2020 and may be subject to revision.

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1. Key points

- Malaysia has 19 government-run, 350 registered and over 1000 unregistered residential aged-care facilities
- Home-based long-term care is currently unregulated in Malaysia
- Welfare Department and Ministry of Health officials work closely with academics, care home representatives and civil society representatives to reach out to care homes
- Malaysia has adopted a mass-testing strategy for all care homes, registered and unregistered, a rate of positive tests for 8% of care homes and of 0.3% staff/residents was reported after 180 of 1300 homes were screened.
- An “older persons” cluster has been reported which involved at least one care home.
- Care homes lack basic PPE and have difficulty observing physical distancing within their confined spaces.
- No visitors are allowed 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.

2. Introduction

This is a preliminary report on the impact of COVID-19 on vulnerable older Malaysians residing in the long term care facilities (LTCF) / Nursing Homes(NH). This provides an overview of key events and measures introduced at a 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 confirmed its first sporadic case of Covid-19 in our community [1].

Based on the population clock at the time of reporting, Malaysia’s population stands at 32,760,472 [2]. As of July 2019, it was estimated that the share of the Malaysian population aged over 65 years was 6.7 percent. Malaysia is currently facing the prospect of an aging population, and the latest statistical data predicted this to be happening as soon as in 2030 [3]. With this pandemic largely affecting older persons and those with 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 stakeholders, as well as the 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 recovery 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 18 May 2020, there were a total of 6,894 confirmed cases of SARS-CoV-2 infection in Malaysia, with a total of 113 deaths.

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 as 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 a Kluster Warga Emas (Golden Years Cluster) with Pusat Jagaan (Care Centre) that included a total of 36 affected individuals and five deaths, located at the Petaling and Klang Health Districts within the state of Selangor [6]. It was not revealed whether all 36 affected individuals were actually care home residents. Informal, unconfirmed sources suggest that two of the cases who died were from a single care home. Five members of staff and three other residents also tested positive from that same care home. The source of infection was from the discharge of a resident from hospital. The other confirmed cases within the cluster are therefore likely to be patients and staff from the hospital outbreak and their close contacts. All five deaths from that single cluster were older adults who were frail with multiple comorbidities. No other clusters involving care homes have been reported by the Ministry of Health Malaysia.

Screening activities started on 4 May 2020. As of 21 May 2020, a total of 7,498 residents and staff has been screened from a total of 182 care homes from the estimated 1,350 homes. They found 18 cases in total from 15 care homes, indicating that COVID-19 was present in 8% of care homes [7].

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, for instance, positive cases arising from those who returned from abroad has led to the government setting up quarantine facilities at hotels. All returned citizens were swab tested on arrival at these quarantine facilities, and 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 of illness, after which those with mild or no symptoms are moved to makeshift hospitals and only discharged after negative tests. After the news of the transmission of SARS-CoV-2 at a mass gathering in a mosque in Seri Petaling, Kuala Lumpur [8], a movement control order was imposed nationwide, and has been in operation since 18 March 2020. The movement control order has only just started to be relaxed since two 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 businesses that are able to open. Businesses have also chosen to remain shut as they struggle to comply with the strict standard operating procedures. Schools, universities and businesses where social distancing is considered challenging remain closed [9].

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 highest number of people. Mass testing has been conducted in hotspots, particularly areas where enhanced movement control orders have been enforced and among vulnerable groups, including care homes and foreign workers.

4. Brief background to the long-term care system

Malaysia has 17 government-run residential homes and 2 government-run nursing homes. There are an additional 350 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, or the Ministry of Health under the Private Healthcare Facilities Act. As of this year, all long-term care facilities will be registered under the new Private Aged Care Facilities Act 2018 which will be enforced in 2020 by the Ministry of Health. Over 1000 long-term care facilities in Malaysia, however, remain unregistered [10]. 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 to run 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 NGO or privately run.

Home care is usually provided by foreign domestic workers, called "maids", who are engaged through agencies from mainly Indonesia, Philippines, Cambodia and Sri Lanka [11]. Home

“nurses” which are usually contracted for a minimum of 8 hours a day, is available for RM15-25 (USD 4-6) per hour, 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 voluntary programme to assist older persons living in the community with tasks such as shopping, financial transactions or just a general chit-chat. The volunteers receive a small cash incentive in return for two visits per month. 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. 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.

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 who developed an interim Recommendation for the Prevention of COVID-19 Transmission in Public, NGO and Private Agecare 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 [12]. The Malaysian Welfare Department also provided cash disbursement to individual care homes, as part of the federal government’s welfare package [13].

The adoption of these interim recommendations was announced by the Director General of Health on 16 April 2020, with an expression of gratitude towards those who contributed. Subsequently, on 2 May 2020, the Director General of Health announced that all care home staff and residents will be tested and the initiative will include unregistered care homes as part of the country’s measures to secure the safety of its most vulnerable population, as it seeks to ease lockdown measures.

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 new foreign domestic workers. Homecare providers are also unable to provide new services at this time due to the movement control order. Home care services have not been listed as essential services throughout the Movement Control Order, severely restricting the Home Care Providers' ability to continue to deliver care. In addition, they lack personal protective equipment, 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 relative home. Many feared 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, as were 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 refused to pay for the additional cost of PPEs and testing after discharge. Care home providers who were 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.

However, with horrifying reports from Europe and US about 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 PPE for new admissions, there does not appear to be any effort the government to distribute PPE 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 [14,15].

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 has dementia and exhibits severe behavioural difficulties if the family member does not attend. Contactless temperature measurement, symptom screening, and travel and health declarations 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 that transmission in their care homes would wipe 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 (MCO). 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 have been told 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 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.

As soon as an outbreak was recorded, contact tracing was immediately carried out and all the residents of the care home who had been in contact (potential cases) were 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 [16].

Community health care for older adults is 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 [17]. 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 COVID19 has been developed.

5.4.1. Measures to prevent spread of COVID19 infection

Home care operators and home help volunteers are told to cease operations throughout the Movement Control Order.

5.5. 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.

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 Welfare and Health sectors willingly worked with lobby groups and NGOs to protect the care home very early on the second wave which started on 10 May 2020. The desire to 'do well' in terms of COVID-19 control and the feeling of solidarity 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 the alarm and sparked a series of responses which finally led to mass testing of care home staff and residents.

While many other countries, particularly in Europe and North America, 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 homes 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 and 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 [18].

6.1. Short-term calls for action

With widespread testing now a reality, the next challenge is to ensure the delivery of PPE to care homes throughout the country, regardless of legal status. It remains unclear who will pay for the PPE, which are expensive, and therefore not generally affordable to care homes, nor to adult children to have to pay care home bills (on average RM 3,000 per calendar month, whereby the average household income for Malaysian is RM 6,000 per calendar month). The interim recommendations development group has now obtained funding from the World Health Organization to facilitate coordinated efforts to train care home staff on infection control measures and supply PPE to these facilities.

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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