INDUSTRY CODE FOR VISITING RESIDENTIAL AGED CARE HOMES DURING COVID-19

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The Australian Health Protection Principal Committee, the Department of Health, consumers and aged care peak bodies have revisited industry codes to support aged care providers make informed decisions regarding visitation during the ongoing COVID-19 pandemic.

As the Aged Care sector moves to the 'COVID-19 Normal' phase, aged care providers must adopt visitation approaches that are more open, while increasing availability and access, and managing the ongoing risk of an outbreak in their facilities.

Key Items:

- Guidelines for visitation to residential aged care facilities have been revised to provide more proportionate protection to residents.
- Revised guidelines now include a tiered approach outlining how residential aged care providers can respond to COVID-19.
- The new 'Tiered Escalation' model allows residential aged care providers to escalate or de-escalate their response depending on the COVID-19 situation they are facing.
- Fewer restrictions will be placed on visitors where there is no community transmission (Tier 1), and ramped up if the facility is located within a defined hotspot (Tier 2) or when there is a COVID-19 outbreak in the community (Tier 3).
- The 'Tiered Escalation' model should be used to determine and continually assess the level of visitation to aged care residents and additional restrictions required to protect residents against the ongoing risk of COVID-19.

OBJECTIVE

The objective of the Code is to provide an agreed industry approach to ensure aged care *residents* are provided the opportunity to receive *visitors* during the COVID-19 pandemic, while minimising the risk of its introduction to, or spread within, a residential care home.

Moving into COVID Recovery phase and COVID Normal

As we move away from the COVID-19 recovery phase to COVID-19 normal, the continued risk of COVID-19 entering an aged care facility remains a risk that needs to be managed to ensure the physical and emotional wellbeing of all residents. home must be balanced with the personal welfare and mental health of residents. To assist, the AHPPC's *COVID-19 Escalation Tiers and Aged Care Provider Responses* and *Revised AHPPC Advice on Visitation Guidelines* should be used to help make informed decisions on appropriate changes to visitation based on community transmission rates.

Advice from the AHPPC supports providers implementing the least restrictive visitation response appropriate to their local COVID-19 situation and reaffirms the importance of the aged care home screening processes. An aged care home should not remain at a higher *Escalation Tier* any longer than necessary.

Aged care providers should be prepared to step-up and step-down based on local or state/territory public health advice/Directions, from the Aged Care Response Centre within the relevant State or Territory, or

their risk assessment at the local level. Movement to the lower *Escalation Tier* should occur as quickly as possible, again in line with public health advice.

The level of limitation on visitation in line with the *Escalation Tier*s should be based on public health unit advice, State/Territory direction, or based on the aged care providers knowledge of emerging risk while awaiting governmental advice or direction. This includes the type of visitation restrictions implemented and attendance by a resident to locations external to the residential aged care facility.

Aged care providers should, during periods at the higher Escalation *Tier*s, take actions to ensure the maintenance of nutritional, physical, emotional and psychosocial wellbeing of resident's in RACFs and to balance actions to support the residents personal welfare with their human rights.

Escalation *Tier*s (*Tier 1*, *Tier 2*, *Tier 3*)

The Code refers to *Escalation Tier*s as articulated by AHPPC and replicated in Attachment A, Table 1. The Escalated *Tier*s of three levels outline a framework where *Tier 1* (the lowest *Tier*) represents no transmission or no locally acquired cases, and *Tier 3* (the highest) represents community transmission of COVID-19 in the local community. Each *Tier* provides an overview of the:

- situation or scenario that is commonly seen against each *Tier;*
- overarching public health objective against each *Tier;*
- focus of action that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

Provider actions by escalation for visitation and external visits by residents

Table 2 of the AHPPC advice replicated in Attachment A provides a detailed list of the actions that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

It is important to note that:

- the primary focus should be on preventative action;
- any action that is required at *Tier 1*, will automatically be required at *Tier 2* and *Tier 3*;
- in line with the *Aged Care Quality Standards* and as a matter of best practice, residential aged care providers should review the advice in Table 2 (at Attachment A) to assist in determining whether their current practice is in line with this advice.

Below are a number of examples to help illustrate how the *Escalation Tier*s should be applied, alongside the AHHPC advice and the *Industry Code for Visiting Residential Aged Care Homes during COVID-19.*

Example 1: No community transmission

In a location where there is no community transmission, providers should follow *Tier 1* requirements to prevent the introduction of COVID-19 into their homes and prepare for the event of a potential outbreak.

Visitation procedures and visitation hours should reflect pre-COVID arrangements, while maintaining screening procedures. In the scenario where there is no community transmission in the State/Territory *Tier 1* approaches to visitation should be applied.

Example 2: Localised and contained outbreak

During the event of a localised outbreak, providers should apply the most appropriate *Tier* for their situation and should not remain in a higher *Tier* any longer than necessary. Providers should be testing staff regularly while leaving sufficient time for contact tracing.

For example, an outbreak occurring in Shepparton as the result of a person travelling from a hot-spot area. Providers promptly escalated procedures from *Tier 1* to *Tier 3*. Local transmissions were monitored for 48 hours before the situation was de-escalated to *Tier 2*.

Example 3: Localised outbreaks small, prolonged community transmission

Referring to instances where there are outbreaks in some areas and not in others.

For example, in Greater Western Sydney some suburbs continue experiencing localised outbreaks while others had no community transmissions. This may have a greater likelihood and additional risk of individuals moving between suburbs, increasing the risk of spreading the virus.

During this situation, providers must be vigilant and should fluctuate between *Tier*s as necessary, depending on transmission rates in their suburb as well as surrounding areas. They should also take note of where their staff are based and transmission rates in those areas. Facilities closer to the epicentre of outbreaks may be *Tier 3*, with bordering suburbs being at *Tier 2* and further suburbs at *Tier 1*.

Importantly, providers should be implementing the least restrictive approach and the lowest *Tier* appropriate for their location.

Example 4: Significant community transmissions

In an area experiencing significant community transmissions providers will be at *Tier 3*. During this time, it is important they consider visitor restrictions in line with the *Industry Code for Visiting Residential Aged Care Homes during COVID-19*, particularly Principle 7 in relation to residents requiring additional social supports. The movement to the lower *Tier* should occur as quickly as practicable, in line with the State or Territory Directive.

Example 5: State or territory emergency or health directives

Where the State or Territory Health Directive requires facilities to restrict visitation access to no visitors (similar to Principle 7) this should be considered *Escalation Tier 3* until otherwise directed. Once the direction is lifted the visitation should return to the appropriate lower *Tier*. The movement to the lower *Tier* should occur as quickly as practicable, in line with the State or Territory Directive.

PRINCIPLES

1. At all three *Escalation Tier*s, providers will continue to facilitate visits between *residents* and *visitors* consistent with the Charter of Aged Care Rights and *State or Territory Emergency and Health Directives*. *Visitors* include a *resident's* family, families of choice and friends. All volunteer types should be permitted during *Tier 1* and *Tier 2*. Some facilities may decide not to permit general volunteers during *Tier 3*. However it is important that residents maintain access to the Community Visitors Scheme during *Tier 2* and *Tier 3*. Accordingly, the code has been updated to recognise CVS as a type of visitor worker that should be permitted at all *Tier*s.

2. During periods requiring *Escalation Tier 2* or *Tier 3* response, visits may occur in a variety of ways (such as in a resident's room, outside in a courtyard or a designated visiting area) and may be supplemented with *additional ways to connect* a *resident* and their *visitors* (such as utilising technology, window contacts or balconies). Where *additional ways to connect* (such as a window contact) are not effective for the *resident* (e.g. people living with dementia or sensory loss) the home will provide alternate approaches. The range of visits and additional ways to connect made available will be negotiated between *residents* their *visitors* and staff of the homes.

3. During periods of *Escalation Tier 2* or *Tier 3*, aged care homes may be required to limit the overall number of people in a facility to meet physical distancing and hygiene requirements. If there is a suspected or actual local cluster of COVID-19 in surrounding suburbs or a suspected/known case of COVID-19 within a home, the home may be required to temporarily increase restrictions on *visitors* These may include restricting the overall number of visitors, reverting to shorter visits, only offering additional ways to contact or where required temporarily exclude visitors entirely. Such measures may be required to minimise the risk of the introduction of COVID-19 into a residential care home. In such circumstances the facility may preference visits for circumstances covered by Principle 7 of the Code.

4. During all *Escalation Tier*s, the wishes and preferences of *residents* will be at the centre of all decision making in relation to who visits them, and their choices will be sought and respected, unless the visitor is prohibited under state/territory directives. Visits between *residents* and their *visitors* are to occur in a manner consistent with infection prevention and control guidelines including provisions relating to the use of designated areas for visits and the use of social distancing practices.

5. At all three *Escalation Tier*s existing legislation and regulation continue to apply during COVID-19 including the Aged Care Act and its related Principles, the Aged Care Quality Standards, the Carers Recognition Act 2010 and Charter of Aged Care Rights. Providers will continue to ensure person centred approaches to care including that approaches to the use of restraints are used in accordance with the *Quality Care Principles*. The Code recognises that aged care homes must comply with the requirements of the *State or Territory Emergency and Health Directives* which takes precedence over the Code. Included within these *Directives* is a legal requirement that all *visitors* must provide proof of immunisation for the 2020 influenza season, unless they provide evidence of a medical exemption from their treating medical practitioner.

6. At all three *Escalation Tier*s, no *visitor* should attend an aged care home if they are unwell, have a temperature of greater than 37.5 degrees Celsius[1], history of fever (e.g. chills, night sweats), cough, sore throat, runny nose, shortness of breath or displaying any cold/flu, respiratory or COVID-19 related symptoms (see here for COVID-19 symptoms) or if they have recently travelled from a designated hotspot town/suburb (as determined by States or Territories Health authorities). *Visitors* must comply with the home's infection prevention and control measures. At a minimum, the entry requirements include being required to respond honestly to screening questions about COVID-19 risk factors, demonstrate an up to date flu vaccination; and complying with visitor requirements which include

[1] SA direction is 38.0 degrees

mandatory hand hygiene, being temperature checked upon arrival, wearing Personal Protective Equipment (PPE) if required, attending to social distancing and hygiene requirements and remaining in a *resident's* room or designated visiting areas.

7. During Escalation *Tier 2* or *Tier 3*, there are circumstances which require additional consideration while maintaining visits for the following "social supports" circumstances:

    a. *Residents* who are dying should be allowed *in-room visits* from loved ones on a regular basis. The number of *visitors*, length, frequency, and nature of the visits should reflect what is needed for the person to die with dignity and comfort, taking into account their physical, emotional, social and spiritual support needs. Erring on the side of compassion is important, given the difficulty in predicting when a person is going to die.

    b. *Residents* who have a clearly established and regular pattern of involvement from *visitors* contributing to their care and support (this could be daily or a number of times per week and, for example assisting a *resident* with their meals or with essential behaviour support such as for people living with dementia) must continue to have these visits facilitated.

    c. *Residents* with a clear mental health issue - provision of support to maintain the mental wellbeing of the older person, where a serious mental illness is known or emerging and where the maintenance of social and family connection may contribute to relieving social and emotional distress for the resident.

8. During *Escalation Tier 2*, consideration should be given for more flexible approaches for Visits from family, families of choice and friends who travel extensive distances to visit the resident. A prior agreement between the visitor and the home will be required to determine if an extended-duration visit is able to be accommodated.

9. With all *Escalation Tier*s, V*isitors* may be subject to procedures such as booking systems and screening procedures. This may have restricted length of visits during *Tier 2* and *Tier 3* to ensure as many people as possible can visit. A flexible and compassionate approach to visiting times should be utilised. *Residents*, *visitors* and the home will work together to identify suitable visiting times and frequency, taking into account the constraints facing all parties, including those *visitors* who have work related restrictions.

10. At all three *Escalation Tier*s, *Residents* have the right to continue to receive letters, parcels including gifts, non-perishable food and communication devices to the home. Perishable foods delivered are to meet food handling/safety guidelines. During periods requiring *Escalation Tier 2* or *Tier 3* preparedness escalation only delivery of these parcels may be subject to additional appropriate infection prevention and control measures, proportionately applied based on the current prevalence of COVID-19 in the suburbs and towns surrounding a particular aged care home. The home may require these deliveries to be made known to the home's staff so that infection prevention and control measures can be applied prior to delivery to the resident. This right continues during periods requiring *Escalation Tier 3* or when potential, suspected or confirmed cases of COVID-19 occur within a home, noting the requirement for screening and adjustment in delivery mechanisms.

11. During all *Escalation Tier*s, regular and responsive communication between families and the home will increase in circumstances where there are increased visitor restrictions. If increased visitor restrictions are required, they should be implemented in line with the *Escalation Tier*s, a transparent manner with open and clear communication to *residents* and relevant family members of the need to each *Escalation Tier*s. The expected review period for de-escalation to a lower *Escalation Tier* should also be communicated. During such periods the home will provide alternate communication approaches, including assistance to use these, to assist *residents* to remain in touch with their loved ones.

12. During *Escalation Tier 1* or *Tier 2*, *residents* can continue to use public spaces within the home, including outdoor spaces using physical distancing measures as required by COVID guidelines and within the constraints imposed by the layout of each home.
13. During all three *Escalation Tier*s, *Residents* right to access medical and related services (e.g. repair of hearing aids or glasses, urgent dental care, mental health support) will be maintained. During *Escalation Tier 2* or *Tier 3* support to access medical and related services may include the use of technology such as telehealth where deemed medically appropriate and will support the right service to ensure the best health outcome for the resident. On return the resident will go through a screening process which should be proportionate to the level of risk. Self-isolation or quarantine is not required during *Escalation Tier 1* or *Tier 2*. Self-isolation or quarantine should only occur during *Escalation Tier 3* if directed by a public health unit or upon recommendation from the discharging medical practitioner from the appointment.
14. During *Escalation Tier 1* or *Tier 2* periods of preparedness escalation external outings and visits are permitted for residents and visitors where these can be conducted in a safe manner, noting these may not be permitted during *Escalation Tier 3*. This means that there are appropriate infection prevention measures in place and an agreement by the resident and family to provide accurate information, and engage in risk mitigation procedures while on the outing/family visit and screening procedures on return. Providers will provide residents, family and representatives with information on their procedures and the impacts of non-compliance with those procedures prior to the visits/outing. It is reasonable for aged care providers to request residents, families and representatives to document their agreement and compliance with this procedure.
15. Providers will vary their own response in line with *Escalation Tier*s outlined by AHPPC. Movement to *Escalation Tier 2* or *Tier 3* may be required under a State/Territory directive, in response to public health unit advice or based on the providers own assessment of their status as an *Escalation Tier 1*, *Tier 2* or *Tier 3*. Responses by providers including *visits* should continue to be in line with this Code and the *State or Territory Emergency and Health Directives.*

RIGHTS

Providers

- To mitigate risk of infection by refusing entry to their home to anyone, or requesting that a person leave the premises, for any justifiable reason consistent with this Code.
- To move into increased *visitor* restrictions when an outbreak (including non-COVID-19) occurs within the home, or local clusters in the surrounding suburbs and towns of the home occur or if there are other extraordinary circumstances that require it, and usage of such circumstances will be closely monitored.

Residents* and *Visitors

- *Residents* receive *visitors* and access aged care homes in accordance with the entry requirements and with the maximum frequency and length possible.
- To receive timely and regular updates and information about what is happening in the Home, consistent across the whole resident population, and with increased frequency of communication local COVID-19 prevalence and transmission risk.
- To maintain contact with their local community outside the home, including to participate in religious and cultural gatherings via alternate means such as online or phone.
- To be provided with *additional ways to connect* such as window contacts, video conference or telephone calls in addition to a limited number of in-person visits.

- To receive/deliver gifts, clothing, food and other items.
- To transfer to other accommodation or an alternate residential aged care home, following clarification of any public health directives, residents wishes and consideration of support needs.

RESPONSIBILITIES

Providers

- Appropriately support staff in order to facilitate visits including *in-room visits*, *in-person visits*, by a *resident's visitors*, including written processes and procedures.
- Ensure *additional ways to connect* such as video conference or telephone calls to compensate for limited visits.
- To ensure that the knowledge of, easy access to, and cooperation/collaboration with OPAN advocates or other formal advocates are provided and that the legal representatives of *residents* (including Power of Attorneys, Guardians and Health Attorneys) are heard, and their substituted decisions are upheld where able and lawful.
- Provide timely and regular updates to *residents* and their nominated representative/guardian/attorney including any relevant government directives. Proactive communication to occur to *residents* and families where an outbreak occurs, delivered consistently across the resident population.
- To ensure all staff are vaccinated under State/Territory Directives and Australian Government Guidelines.
- State/Territory health authorities have a responsibility to inform providers where there is a local cluster of COVID-19 near a home, and the home has a responsibility to follow State/Territory directions.

Residents* and *Visitors

- Not to visit when unwell or displaying any signs of a cold/flu, respiratory or COVID-19 symptoms.
- To respond truthfully to COVID-19 screening questions asked by the home's staff.
- To treat all staff with respect and courtesy, and to follow their instructions.
- Contact the home before visiting, to secure a mutually convenient time.
- To follow visiting requirements including providing evidence of up to date influenza vaccination, infection and prevention control measures such as washing hands, use of visiting windows, remaining in *residents*' rooms, or in designated areas and Social Distancing and Hygiene Requirements – as directed by the aged care staff.

CODE COMPLAINT PROCESS

Stage	Provider	*Residents* and *Visitors*
1. Initial request	• Wherever possible and appropriate meet the request and facilitate a visit at the next available opportunity. • If not possible explain the reason and the alternative approach you propose. • Have documented procedures for handling requests for visits. • Communicate any internal review/appeals processes if you cannot resolve conflict with the person requesting a visit. • Consider use of guidance from the Aged Care Quality and Safety Commission.	• Speak with home's manager and be specific about: – what you're asking for; and – why you're asking for it. • At all times the *resident* or their representative has the right to engage an aged care advocate of their choice to support the *resident's* request to see *visitors*. This may include their legal representative (e.g. Power of Attorney, Guardian) OPAN advocate or another nominated representative. • Use any or all complaints processes whether informal or formal for complaints and feedback or specifically regarding COVID-19.
2. Supported request	• If receiving a call from OPAN try to resolve the complaint raised. • If an aged care provider wants someone other than the home's manager to be contacted for escalated request – please inform local OPAN organisation. • If you believe the request from OPAN is unreasonable, or you are unable to deliver it, you can contact your peak body's member advice line to discuss. • If you need to lodge a complaint regarding the OPAN advocate this can be facilitated at https://opan.com.au/contact-us/.	• Call Older Persons Advocacy Network (OPAN) 1800 700 600 or visit https://opan.com.au to receive support and advice from a trained advocate. • OPAN will support you in speaking with the manager of the aged care home, or may with your permission contact the home to advocate on your behalf to be able to visit. • OPAN can also assist *residents* and representatives in making a complaint to the Aged Care Quality and Safety Commission.
3. Complaint to the Aged Care Quality and Safety Commission	• Work with the Commission to respond to the complainants concerns and provide any information requested to demonstrate how you have met your responsibilities.	• If you are not happy with the decision of the home (or at any time), you can make a complaint to the Aged Care Quality and Safety Commission by calling **1800 951 822 at any time** (free call) or by visiting https://www.agedcarequality.gov.au/making-complaint.

DEFINITIONS

Additional Ways to Connect – During periods of normal operations (*Escalation Tier 1*) the following methods of connection may be provided in addition to face to face visits:

- **Videoconference** service such as Skype, Zoom etc
- **Telephone calls**

- **Window contacts –** in addition to visits, contact with residents may be made via a window. During an outbreak of COVID-19 in the facility, or a local cluster in the surrounding suburbs or towns, window contacts may become a primary form of contact between residents and visitors for a period of time.

These practices should not be a primary method of visiting, however during periods where an aged care home has enhanced restrictions in place (*Escalation Tier 2* and *Tier 3*), these additional ways to connect may be used in place of visits or as an additional way to connect during restricted visits.

Commonwealth definition of a hotspot **-** The Commonwealth trigger for consideration of a COVID-19 hotspot in a metropolitan area is the rolling 3 day average (average over 3 days) of 10 locally acquired cases per day. This equates to over 30 cases in 3 consecutive days. The Commonwealth trigger for consideration of a COVID-19 hotspot in a rural or regional area is the rolling 3 day average (average over 3 days) of 3 locally acquired cases per day. This equates to 9 cases over 3 consecutive days.

Designated Areas – A designated area is an area set aside by the home where visits between *residents* and *visitor/s* are to occur during the COVID pandemic. Designated areas are put in place to allow for safe interactions between *residents* and *visitors* that minimise the risk of infection and that allow for social distancing requirements. These areas will be particularly important for residents living in shared rooms, or where an individual resident indicates they do not wish to receive visitors in their room.

Local Cluster –AHPPC recommends that facilities return to *Escalation Tier 2* or *Tier 3* higher levels of protection (such as restricting visiting service providers) if there are recent cases of COVID-19 acquired in the local vicinity of the facility. A guide would be that there are cases in the surrounding suburbs or town that have not been acquired overseas.

Resident – Is the care recipient under the Aged Care Act. The views and wishes of the older person (resident) about who visits, and how visits are conducted should be sought in the first instance. Where this is not possible, then the views of their substitute/supported decision maker (attorney) should be sought, noting that it is the substitute/supported decision maker's obligation to make the decision in line with the wishes and preferences of and in accordance with how the older person would have made them.

Short Visit –. During *Escalation Tier 3*, in order to facilitate as many families and friends as possible to see a *resident*, booking systems and associated time restrictions may be in place. Where increased restrictions apply during *Escalation Tier 3* visits may be limited to between one and two hours. Generally, one hour is the minimum time for short visits. For someone with dementia, or for the situations covered by Principle 7 of this Code, it is preferred that no minimum of visit is applied in line with AHPPC current advice

State or Territory Emergency and Health Directives – The following State or Territory Emergency and Health Directives, relevant to aged care which are in force as at 19 November 2020 include:

- Australian Capital Territory
- New South Wales[2]
- Northern Territory
- Queensland
- South Australia
- Tasmania
- Victoria
- Western Australia

These government *Directives* are legally binding on aged care providers and individuals. They require all *visitors* to provide proof of immunisation for the 2020 influenza season to be allowed entry.

Physical Distancing and Hygiene Requirements – The general physical distancing requirement is 1.5m between people, practice hand hygiene (i.e. wash their hands with soap or hand sanitiser for a minimum of 20 seconds frequently) and ensure appropriate cough etiquette (for example coughing or sneezing into

[2] Additional advice from NSW Health is here: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/covid-19-racfs-advice.pdf

your elbow not your hands). However, each state and territory specifies the number of square metres that determines the maximum number of people in the building at any one time[3] (including residents, staff and visitors) and which may be different based on building size. A sign at the front door of the home should clearly identify the maximum number of people that may be in the home at any one time.

Surrounding suburbs or town / local vicinity – The AHPPC advice identifies that "AHPPC recommends that facilities return to a higher level of protection (such as restricting visiting service providers) if there are recent cases of COVID-19 acquired in the local vicinity of the facility. A guide would be that there are cases in the surrounding suburbs or town that have not been acquired overseas.

Visitor/s – *Visitors* include any person a *resident* chooses to see including their family, family of choice, friends, religious or spiritual advisors, Community Visitors Scheme volunteers. It is not up to the aged care home or its staff to determine who is or is not eligible to be a *visitor*, including who is a "close family member" or a visitor to provide "social support". The presence of a Guardianship order, Power of Attorney or involvement of the Next of Kin does not automatically preclude other people from visiting, though may be informative when prioritising who to let visit when multiple people are requesting visits for the same *resident*.

However, medical and allied health staff, aged care advocates, legal representatives, or carers privately contracted by the *resident* or their family carers are not *visitors* for the purpose of this Code. They are considered workers under the various State Emergency and Health Directives which defines workers to include volunteers. Such workers will be required to comply with an aged care homes' practices including their infection prevention and control measures.

Visit/s – Visits may occur in a range of ways including in a *resident's* room, designated internal areas, gardens or other designated areas. Priority for someone with dementia, or for the situations covered by Principle 7 of this Code may be given in regard to designated visiting areas. Where time limits of a visit need to be applied these should be no less than 60 minutes (except in the case of a short visit due to an outbreak which may be 30 minutes) and only necessary for *in-person visits* such as a designated visiting area that it shared between other residents. Visits will be conducted in accordance with Infection Prevention and Control measures, including *Physical Distancing and Hygiene Requirements* (see CDNA, p10).

- **In-Room Visit** – Occur in the *resident*'s room and may require additional PPE to be worn. In-room visits may not be appropriate when living in shared rooms and in situations covered under Principle 7A of the Code alternative locations should be provided.
- **In-Person Visit** – Occurs in a dedicated area or outside, not behind a protection screen.

Where in-room or in-person visits cannot occur, *additional ways to connect* (including via a balcony, through a gate or behind a window) may be offered as an alternative to minimise the risk of COVID-19 spread.

Visiting Hours – Aged Care Homes may limit visits to specified hours during *Escalation Tier 2* or *Tier 3* only. Effort should be made to ensure that visiting hours are available to enable visitors who work Monday to Friday, 9am – 5pm to visit. The hours available to visit should progressively return to their normal periods prior to COVID-19 as de-escalation to a lower *Tier* occurs. An outbreak in the home (*Escalation Tier 3*), and/or local clusters of COVID-19 in the surrounding suburbs or towns may necessitate a return to shorter visiting hours. Providers must balance operational decisions taking into account their responsibilities to uphold the resident's rights in particular Right 7 and 8 within the Charter of Aged Care Rights.

[3] NSW aged care homes are exempt from the 4 square metre rule.

BACKGROUND

We need to ensure that older Australians remain safe and are protected during the Coronavirus (COVID-19) pandemic. Low community transmissions as a result of Government policies, and the effective efforts of the aged care sector, have prevented widespread outbreaks in residential care homes.

This industry code will be adopted during the period of COVID-19, after which usual practices will return. During other infectious outbreaks only a small number of compassionate visits would be permitted, however it is recognised that COVID-19 will require a sustained period of action compared to the usual period for other infectious outbreaks.

As the local community surrounding an aged care home begins to progressively return to pre-COVID-19 activities, it is important that older Australians generally and residential aged care in particular, maintain caution over a sustained period of months. This means that while most of Australia may have a more relaxed approach to social interactions, some parts of Australia experiencing an outbreak in their local community may temporarily return to a higher level of restricted visitation policies. This means that we need to ensure visiting procedures supporting the rights of older people and can be sustained in a way that also maintains the protection of all *residents* of an aged care home over the longer term.

On 19 June 2020 the Australian Health Protection Principal Committee (AHPPC) provided updated advice regarding aged care homes, building on the initial advice by the Communicable Diseases Network Australia (CDNA) which outlines the management of risk of infection. The new advice:

- recommends "spouses or other close relatives or social supports" are not to be limited in the number of hours they spend with relatives;
- permits children under 16 once again visit aged care homes;
- maintains the requirement for all visitors to be vaccinated against influenza;
- maintains that all visitors should practice social distancing;
- requires staff to screen visitors, educate visitors about social distancing but not supervise visits
- recommends visits should occur in a *resident's room*, outdoors or in a designated visiting area – but not in communal areas;
- limits visits to a maximum of two visitors at any one time per resident;
- permits residents to leave the aged care home for small family gatherings (noting a risk assessment of the proposed visit by the home will need to be conducted);
- recognises that in the event of an outbreak of COVID-19 in the home or local cluster in the community – restrictions on visitations may increase, visits may again be supervised, and external excursions may be suspended.

In addition, state and territory Directives with which aged care providers and visitors must comply were updated, including removing the 2-hour restriction on visitations. Longer visits for other purposes (such as end of life care) are permitted under the current Western Australia directive.

Human rights recognise that all people living in an aged care home have the right to freedom of movement and association, including the right for *residents* to see their families. A human rights approach is fundamental to this Code but does not mean the rights of an individual prevail above all else. An individual's rights must be exercised giving consideration to the welfare and wellbeing of others, or to put it yet another way, one individual's rights should never override the rights of another person, they must be balanced with them. Services will continue a person-centred approach in their relationship with *residents*. The approach and application of the Code will recognise cultural, language and spiritual diversity, cultural or environmental contexts and Aboriginal and Torres Strait Islander peoples and communities.

The Aged Care Quality Standards and the Charter of Aged Care Rights still apply throughout any pandemic (including being informed about care and services in a way they understand such as in their preferred language) and the Aged Care Quality and Safety Commission (ACQSC) has provided specific guidance resources for the aged care sector including about visitor access. Residential care homes, *residents* and *visitors* have successfully worked together to find the right balance between protecting *residents* from COVID-19 and providing them with vital social connections and support. It is important that this collaborative and mutually respectful approach is maintained into the future.

The appropriate place to address concerns under the Code starts with consultation between providers and *residents* and family members to address their concerns locally. This process may include support for the resident or family, or advocacy on their behalf by the Older Persons Advocacy Network (OPAN); and the provider may seek support from its peak body's member advice line where needed.

For clarity, any person can make a complaint to the Aged Care Quality and Safety Commission at any time and this Code does not change those arrangements.

REVIEW DATE

The Code was endorsed on Monday 11 May 2020, reviewed on 29 May 2020, updated on 3 July, 23 July and 20 November 2020.
It will continue to be monitored by the endorsing organisations, any one of whom may request a formal review be conducted if required.

THIS CODE WAS DEVELOPED AND ENDORSED BY:

Aged Care Provider Peak Organisations	Aged Care Consumer and Carer Peak Organisations
• Aged & Community Services Australia • Aged Care Guild • Anglicare Australia • Baptist Care Australia • Catholic Health Australia • Leading Age Services Australia • UnitingCare Australia	• Carers Australia • Council on the Ageing (COTA) Australia • Dementia Australia • Federation of Ethnic Communities Council of Australia • National Seniors Australia • Older Persons Advocacy Network (OPAN)

VERSION 5 – 20 NOVEMBER 2020

Australian Government

BE COVIDSAFE

Visitation Guidelines for Residential Aged Care Facilities

November 2020

The Australian Health Protection Principal Committee (AHPPC) recognised early in the COVID-19 pandemic that residents of residential aged care facilities (RACFs) were particularly vulnerable, and at risk of severe illness from COVID-19. Accordingly, the health and wellbeing of this population has been in the deliberations of the AHPPC throughout the pandemic. AHPPC recommends that all RACFs ensure they are sufficiently prepared to manage a COVID-19 outbreak. Detailed guidance for facilities is available.

AHPPC recognises and acknowledges the significant work of aged care providers, the aged care workforce, families, the community and older people themselves to prevent transmission of COVID-19 within aged care homes.

Moving into COVID Recovery phase and COVID Normal

AHPPC considers the personal welfare and mental health of residents in RACFs is of vital importance. As Australia continues to move towards becoming COVID Safe (during this COVID-19 recovery phase), these factors must be balanced against the ongoing risks of COVID-19 outbreaks in RACFs. Levels of community transmission of COVID-19 (at a local area, suburb, region or jurisdiction level) should influence the escalation tiers and aged care provider responses as Australia and the aged care sector moves towards the COVID Recovery and COVID Normal phases.

The following key principles during COVID Recovery and COVID-19 Normal phases are supported by AHPPC:

- AHPPC supports continuing efforts to proportionately implement appropriate infection prevention and control measures with residential aged care and for other vulnerable populations receiving aged care at home.
- Jurisdictional (State and Territory) health directives must be followed, including adherence to physical distancing, personal hygiene and other recommended infection prevention and control measures.
- AHPPC considers the maintenance of nutritional, physical and psychosocial wellbeing of residents in RACFs to be of vital importance, balanced with their personal welfare, and human rights.
- AHPPC supports visitors (including family, friends, visiting health workers and support staff) to residents of aged care homes in the least restrictive manner possible, in line with the known or likely wishes and preferences of the older person/resident.
- An ongoing and dynamic risk assessment should influence the level of limitation on visitation, the type of visitation restrictions implemented and attendance by a resident to locations external to the residential aged care facility.
- The dynamic risk assessment should be based on the current level of COVID-19 community transmission (both at the location of the RACF and the community of the visiting person) and only occur in a manner that is proportionate to the prevalence of community transmission.
- The 'Tiered Escalation' model should be utilised in determining the level of visitation and other restrictions required.

- Aged care providers should be prepared to step-up and step-down based on local or state/territory public health advice, direction from the Aged Care Response Centre within the relevant State or Territory, or their risk assessment at the local level.
- The restrictions on entry, recommendations on entry to residential aged care, screening and management of staff and visitors and external excursions from residential aged care (for personal or health reasons) outlined in Table 2 below be followed.
- The Industry Code on Visiting Aged Care Homes during COVID-19, should be followed. In particular, Principle 7 which deals with exceptional circumstances in which visitation should be allowed even during Tier 3.
- State and Territory public health units have the ability for aged care providers (and where relevant, community members) to be able to request consideration, on a case by case basis, of exceptions to relevant jurisdictional directions.

1. Purpose and audience

This document is to provide guidance for aged care providers on actions to be undertaken depending on the COVID-19 situation within the community.

The Department of Health has developed the Escalation Tiers and Aged Care Provider Responses framework (Escalation Tiers framework) outlined in Table 1. This has been reviewed against, and is consistent with, the national aged care statements and guidance listed in section 5.

Residential aged care providers are the primary intended audience of this advice.

2. Commonwealth definition of a hotspot

The Commonwealth trigger for consideration of a COVID-19 hotspot in a metropolitan area is the rolling 3 day average (average over 3 days) of 10 locally acquired cases per day. This equates to over 30 cases in 3 consecutive days.

The Commonwealth trigger for consideration of a COVID-19 hotspot in a rural or regional area is the rolling 3 day average (average over 3 days) of 3 locally acquired cases per day. This equates to 9 cases over 3 consecutive days.

3. Escalation tiers

Table 1 is based on the Escalation Tiers framework. It details three proposed escalation tiers and provides an overview of the:

- situation or scenario that is commonly seen against each tier
- overarching public health objective against each tier
- focus of action that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

4. Provider actions by escalation for visitation and external visits by residents

Table 2 provides a detailed list of the actions that residential aged care providers should take in response to a situation of escalating, or de-escalating, COVID-19 outbreak.

It is important to note that:

- the primary focus should be on preventative action;
- any action that is required at Tier 1, will automatically be required at Tier 2 and Tier 3;
- as a matter of best practice, residential aged care providers should review the advice in Table 2 to assist in determining whether current practice is in line with this advice.

5. Aged care response to COVID-19: National statements and guidelines

Key national statements and guidelines reviewed and endorsed by the AHPPC relating to aged care (and developed by the AHPPC subcommittees of Communicable Diseases Network Australia (CDNA) and Infection Control Expert Group (ICEG)) are:

- New National Plan
- CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia
- Coronavirus (COVID-19) Guide for Home Care Providers
- AHPPC Coronavirus (COVID-19) Statement: Recommendations to Residential Aged Care Facilities
- ICEG Coronavirus (COVID-19) environmental cleaning and disinfection principles for health and residential care facilities
- ICEG Coronavirus (COVID-19) guidelines for infection prevention and control in residential care facilities
- AHPPC advice on residential aged care facilities
- AHPPC update to residential aged care facilities about minimising the impact of COVID-19
- ICEG Coronavirus (COVID-19) – Recommended minimum requirements for the use of masks or respirators by health and residential care workers in areas with significant community transmission
- ICEG guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities
- AHPPC Guide to the Establishment of an Aged Care Health Emergency Response Operations Centre.

The Industry Code on Visiting Aged Care Homes during COVID-19 (Industry Code) has been developed by the aged care sector peaks. The principles and approaches within the Industry Code should be considered in supporting the

proportionate controls required to support safe visitation to aged care homes during COVID Safe/COVID Normal. The Industry Code was endorsed by endorsed by National Cabinet on 1 May 2020, and was further updated by the Aged Care Sector peaks on 23 July 2020.

Aged care providers have an obligation to provide care and services in accordance with the requirements of the *Aged Care Act 1997,* including the Aged Care Quality Standards and the Charter of Aged Care Rights. Provider obligations include responsibilities for quality and safety and respecting the rights of consumers, and focus on the outcomes that the community can expect from organisations that provide Commonwealth-subsidised aged care services. In managing the risks of COVID-19, providers need to balance the needs, goals and preferences of consumers to optimise their health and well-being, including in relation to isolation. The Code is not a legislated obligation but complements the regulatory framework by providing clarity on industry expectations of the practices that will support these outcomes for consumers. Evidence of how a service is applying the Code will be considered, where relevant, by the Aged Care Quality and Safety Commission in monitoring and assessing providers in relation to the Aged Care Quality Standards and Charter of Aged Care Rights.

Table 1: Proposed escalation tiers

	TIER 1	TIER 2	TIER 3
Situation	Epidemic* of no transmission or no locally acquired cases; only cases are those from people who have travelled overseas	Epidemic* of jurisdictionally defined hotspots such as: • ocalised outbreaks with cases occurring in: – households, – licenced venues, – fitness centres, – shopping centre • OR – a single case in a setting with high transmission risk such as a correctional facility or a RACF • OR – a flag such as an upstream source not able to be identified	Epidemic* of COVID-19 in the community
Public Health Objective	Prevent introduction of COVID-19	Investigate and control if required Prevent further COVID-19 spread End the chain of transmission	Control COVID-19 transmission Prevent seeding to new areas Clinical care
Focus of Action	Preparedness i.e. getting everything in order	Tier 1 plus a ramp-up of activities such as: • raising awareness • encouraging people in specific locations to come forward for testing • a renewed focus on Infection Prevention and Control (IPC) training • (depending on what is occurring in the community) compulsory mask use; visitation considerations; asymptomatic testing; implementation of single site worker arrangements	Tiers 1 and 2 as well as public health interventions such as: • mask wearing • visitation restrictions • asymptomatic testing • single site worker arrangements • encourage people to work from home • avoiding non essential travel i.e. a full ramp up of all activities

*An epidemic or outbreak is the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time (Source: https://www.cdc.gov/csels/dsepd/ss1978/lesson6/section2.html)

Table 2: Visitation recommended actions by Tier

	TIER 1	TIER 2	TIER 3
RACF RESTRICTION TO ENTRY			
Restriction on entry - staff, including contractors	Limited restriction (as per Appendix A)	Limited restriction (as per Appendix A)	Limited restriction (as per Appendix A)
Restriction to entry - visiting health & other designated support workers (including advocates & CVS)	Limited restriction (as per Appendix A)	Limited restriction (as per Appendix A)	In-reach services (where telehealth or adaptive models of care are not appropriate, applicable or available)
Restriction to entry - visitors	Limited restriction (as per Appendix A)	Limited restriction (as per Appendix A)	Restricted visitation - in line with Industry Code (in particular, Principle 7)
Restriction to entry – groups (more than two people)	Entry with appropriate screening, physical distancing and personal hygiene measures	No entry	No entry
Restriction to entry - new residents & residents returning from hospital (following a non-COVID-19 related illness)	Returning and new residents - appropriate screening and monitoring	Returning and new residents – no entry unless clearance authorised by medical officer/ public health unit.	New and returning residents – no entry unless clearance authorised by medical officer/ public health unit.
Restriction to entry - new residents & residents returning from hospital (following a COVID-19 positive diagnosis)	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the *Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units* is met.	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the *Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units* is met.	Returning residents and new residents: Entry permitted where "Release from isolation" criteria as outlined in the *Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units* is met.
Restriction to entry - partners in care	No restriction	Permitted – with appropriate orientation/training	Permitted – with appropriate orientation/training, and in line with Principle 7 of the Industry Code

	TIER 1	TIER 2	TIER 3
RESIDENTIAL CARE & SUPPORT			
Resident and visitors - symptom screening	Yes	Yes	Yes
Resident - isolation /quarantine	Asymptomatic - not required Symptomatic – isolation/quarantine required	Asymptomatic – not required Symptomatic - isolation/quarantine required with screening based on medical officer/ public health unit advice	Screening and isolation/quarantine when symptomatic, or based on medical officer/public health unit advice for asymptomatic
Resident - common areas	Yes	Limited, with physical distancing or outdoors	Restricted, based on State/Territory directions
Resident - Physical and mental wellbeing	Implement standard measures to maintain and monitor	Implement standard measures to maintain and monitor	Implement alternative measures to maintain and monitor
Resident - Partners in Care support models	Yes	Yes – with appropriate orientation and education, and adherence to infection prevention and control requirements and directions by staff	Yes – with appropriate orientation and education, and ability to use personal protective equipment under staff direction
Resident - alternative models of visitation (e.g. digital, window visit)	Offered if requested	Implement alternative mechanisms	Implement alternative mechanisms
Infection prevention & control - Personal Protective equipment - staff and visitors	Implement as per State/territory health directives	Implement as per State/territory health directives	Implement as per State/Territory directions
Infection prevention & control - Personal Protective equipment - residents	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Implement as per State/Territory health directions

	TIER 1	TIER 2	TIER 3
VISITATION LIMITATIONS & INFORMATION PROVISION			
Infection prevention & control education and information provision - residents and visitors	Yes	Yes	Yes
Visitors - time limitations	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Limitations based on State/Territory directions
Visitor - number limitations	COVID Normal (including small groups) with appropriate risk management procedures in place	COVID Normal (max of 2 visitors at any one time per resident)	Limitations based on State/Territory directions
Visitor - age limitations	Not required	Not required	Limitations based on State/territory directions
Visitation location - within aged care facility	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Limitations based on State/Territory directions
Supervision of visitors	Consistent with residential aged care facility's (pre-COVID) arrangements	Consistent with residential aged care facility's (pre-COVID) arrangements	Escort to and from resident's room
Physical distancing	Yes	Yes	Yes
Personal hygiene measures	Yes	Yes	Yes
Seasonal influenza vaccination	Yes	Yes	Yes

	TIER 1	TIER 2	TIER 3
RESIDENT EXTERNAL APPOINTMENTS/GATHERING			
Resident external appointments - hospital	Yes	Yes	Yes
Resident external appointments - GP/ Allied health	Yes	Yes (where in-reach not available)	Telehealth/In-reach preferable
Resident external excursions - small gatherings	Yes	Yes – numbers/ locations per State & Territory guidance, where group is known and with appropriate physical distancing & personal hygiene	Allowed on a case by case basis – where numbers/locations per State & Territory guidance, where group is known and with appropriate physical distancing & personal hygiene, and with a risk assessment and risk management plan
Resident external excursions - groups	Yes	Yes – per State & Territory guidance, with appropriate physical distancing & personal hygiene	No
Resident external - exercise	Yes	Yes	Yes – Allowed on a case-by-case basis with risk assessment

Appendix A
Advice from AHPPC

Further to Table 2, the following represents advice from AHPPC about minimising the impact of COVID-19 in residential aged care facilities:

Restrictions on entry into RACFs

AHPPC maintains that the following visitors and staff (including visiting workers) should not be permitted to enter a RACF:

- Individuals who have returned from overseas in the last 14 days
- Individuals who have been in contact with a confirmed case within the last 14 days
- Individuals who are unwell, particularly those with fever or acute respiratory infection (for example, cough, sore throat, runny nose, shortness of breath) symptoms
- Individuals who have not been vaccinated against seasonal influenza.
- Individuals who require isolation or quarantine (unless directed by and managed per the direction of the local public health unit)

Recommendations for entry into RACFs

Based on emerging evidence and given the current epidemiological and public health situation in Australia, with low levels of local transmission, AHPPC recommends that:

- children of all ages be permitted to enter RACFs — all visitors, including children, must adhere to restrictions on visitor numbers, social distancing and personal hygiene
- during Tier 2 and Tier 3 escalation periods, visiting service providers such as diversional therapists and allied health professionals be permitted to enter RACFs when their services cannot be provided via telehealth or other adaptive models of care; these providers must adhere to equivalent social distancing and hygiene practices as they have implemented in community settings.
- in-reach services by General Practitioners or allied health providers to aged care homes are the preferred model during Tier 3 escalation periods where telehealth or adaptive models of care are not appropriate, applicable or available. Where this cannot occur, external services should be facilitated with appropriate and proportionate infection prevention and control measures so as to not impact the long term health status of the individual or health care access.
- spouse or other close relatives or social supports are not limited in the number of hours that they spend with their spouse/relative, unless limited by State/Territory directions.

AHPPC recommends that facilities return to a higher level of protection (such as restricting visiting service providers) if there are recent cases of COVID-19 acquired in the local vicinity of the facility. A guide would be that there are cases in the surrounding suburbs or town that have not been acquired overseas.

AHPPC recommends that RACFs who, based on the current environment, need to move to higher Tiers, implement measures to reduce the risk of transmission to residents, including:

- visits should be conducted in a resident's room, outdoors, or a specified area in the RACF, rather than communal areas with other residents
- no large group visits should be permitted at this time, however gatherings of residents in communal or outdoor areas which adhere to social distancing and current jurisdictional requirements for gathering size may be permitted

Visitors must practise social distancing where possible, including maintaining a distance of 1.5 metres. Visitors have a responsibility to supervise any children with them, practise hand hygiene and respiratory etiquette, use PPE as required, and to comply with directions given by RACF staff.

AHPPC recommends that RACF staff should not be required to supervise visits, except during Tier 3 where visitors should be escorted to and from the resident's room. However staff should promote compliance with COVID-19 prevention methods by:

- educating visitors on entry about practising social distancing and hygiene during their visit
- supporting application of required PPE
- placing signage throughout the facility to remind visitors to maintain these measures
- screening visitors on their current health status upon entry to ensure unwell visitors do not enter the facility

In the event a facility needs to return to a higher level of protection (for example, an outbreak of COVID-19 or local cluster in the community), facilities should recommence supervising visitors.

External excursions – groups of residents

AHPPC recommends that external excursions for groups of residents (eg. bus trip) not be permitted in Tier 3 localities. Such excursions can occur under Tier 2, where in line with State/Territory directions, following a risk assessment and use of appropriate infection prevention measures (for example, residents remaining on the bus).

External excursions – small gatherings

Under Tier 2, individuals and family members (close friends, partners, couples or siblings/familial groups in an RACF) should be permitted to leave the RACF to attend gatherings, where the group is known (for example, with family or friends), and where such arrangements are in line with State/Territory directions, and use of appropriate infection prevention measures (including physical distancing and hand hygiene).

Under Tier 3, external excursions which involve small gatherings may occur on a case by case basis, where:

- the group is known;
- the size of the small gathering is in line with current jurisdictional advice and physical distancing and hygiene measures is adhered to during the visit; and
- the RACF has conducted a risk assessment for the visit and implemented proportionate infection prevention and control measures based on this assessment, taking into account the purpose of the excursion, local epidemiology, and number of people attending and the feasibility of physical distancing. The RACF should maintain a record of the visit location, number of people in the gathering and the date of visit.

Residents

The AHPPC advice recommends:

- active screening for symptoms of COVID-19 in residents being admitted or re-admitted from other health facilities and community settings should be conducted
- no new residents with COVID-19 compatible symptoms should be permitted to enter the facility, unless the person has recently tested negative for COVID-19 and clearance authorised by the Public Health Unit (PHU)
- residents admitted from other health facilities should be assessed by appropriate medical staff prior to admission to the facility and appropriate and proportionate infection prevention practices should be implemented for residents returning from treatment or care at other facilities (This does not apply to day visits e.g. for outpatient visits).

There is no requirement for routine testing on admission or re-admission, unless clinically warranted. Clinical judgement should be applied — for example, where a patient is coming to the RACF from an area with known community transmission.

One-off screening on entry or re-entry to the facility should comprise a questionnaire about symptoms of COVID-19 and an initial temperature reading.

If otherwise unexplained symptoms are present or indicated in the response to the questionnaire, or fever is present, the resident should not be admitted to the facility. If admission is unavoidable the resident should be isolated and tested immediately, and appropriate infection prevention and control precautions should be implemented. The resident should be managed as per the CDNA recommendations for suspected COVID-19 cases.

Requirement for visitors to be vaccinated against seasonal influenza

Older Australians are at higher risk of morbidity and mortality due to influenza than the general population. While there is no vaccine or treatment for COVID-19, vaccination is a key protective factor against influenza infection. Unvaccinated staff and visitors pose a risk of introducing influenza into a RACF. This would burden the health system and endanger older Australians residing in RACFs.

As a protective measure, AHPPC continues to advise that only visitors and staff who have been vaccinated against influenza may enter RACFs. Individuals with a valid medical reason to not be vaccinated may seek a medical exemption to enter RACFs, in accordance with their jurisdictional requirements.

Management of staff and visitors that are ill

COVID-19 can be introduced into RACFs by staff and visitors who are unwell, which can result in significant outbreaks. RACFs must advise regular visitors and staff to be vigilant in monitoring their health for signs of illness, and staying away from RACFs if they are unwell.

RACFs should undertake health symptom screening of all people upon entry as recommended by the Aged Care Quality and Safety Commission. Residential aged care providers need to take responsibility for the health of visitors and staff to whom they grant entry to protect our most vulnerable community members.

Staff and contractors who have symptoms of COVID-19 should be excluded from the workplace and be tested for COVID-19. Staff must immediately report their symptoms to the RACF, even very mild symptoms, and not go to any workplaces. Sick leave policies must enable employees to stay home if they have any of the COVID-19 symptoms, as outlined on the Department of Health website.