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

UPDATED 6 August 2021

INDEX

ENDORSEMENT AND REVIEWS

The Code was endorsed on Monday 11 May 2020, reviewed on 29 May 2020, updated on 3 July, 23 July and 20 November 2020 and reviewed on 6 August 2021. 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 • 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' Councils of Australia • National Seniors Australia • Older Persons Advocacy Network (OPAN)

REVIEW UPDATE

The Industry Code for Visiting Residential Aged Care Homes During CoVID-19 (the Code) was reviewed on 6 August 2021, and re-endorsed by Australian Health Principal Protection Committee (AHPPC) given the emergence of more virulent strains of COVID-19. AHHPPC has released advice to implement the National Cabinet decision that at least the first dose of a COVID-19 vaccine be administered by 17 September for residential aged care *Workers*.

The AHPPC advice defines the which parts of the aged care workforce future updates to *State/Territory Health Directives* will apply to, and the three exemptions (medical exemptions, temporary exemptions or pregnancy) that may be included. The workforce that must receive a vaccination by mid-September includes:

- Aged Care Provider Workforce (including direct care workforce, administration staff, ancillary staff, lifestyle/social care, students and volunteers engaged by the Home);
- In-reach services workforce (Visiting medical practitioners).

The Code supports the mandating of vaccination for *Workers* in line with infection prevention and control measures (and with appropriate exemptions). The Code supports the AHPPC statement that "vaccination is strongly encouraged for anyone entering" a *Home* including *Visitors*.

AHPPC's advice confirms that the following workforce categories are not subject to the mandatory vaccination requirements but affirmed that "vaccination is strongly encouraged for anyone entering a Home, particularly these groups:

- In-reach services workforce (pharmacist, allied health professionals not engaged by the Home);
- Regular in-reach/contractors (AN-ACC/ACAT/RAS Assessors, ACQSC staff, NACAP/OPAN staff, tradespeople, delivery drivers, hairdressers, regular pastoral care workers);
- Volunteers/Visitors (CVS volunteers, Partners-in-Care, volunteers engaged outside the RACF, family and friends);
- Irregular in-reach/contractors (librarians, solicitors, personal pastoral care workers, on-off irregular trade delivery, trade union officials).

These groups should be allowed entry in line with the Code and *State/Territory Health Directives,* with appropriate screening (including recording of vaccination status) and proportionate infection prevention and control measures. Once Australia reaches the point that every Australian has been offered a COVID-19 vaccination, the Code will be reviewed to consider if a requirement is needed that all *Visitors* must have a COVID-19 vaccination to allow entry into a *Home* (noting there may be appropriate medical exemption from receiving the COVID-19 vaccine).

The requirement of contracting services to disclose the COVID-19 vaccination status of their contractors entering a *Home* may be addressed in the contractual arrangements / documentation between the contracting agency and the aged care provider. All contractors must adhere to the screening procedures and requirements of the *Home* they are entering. Contractors are allowed to enter a *Home*, after 17 September 2021, even if they are not vaccinated, subject to *State/Territory Health Directives*.

Information from the Australian Government Department of Health is available here for staff, and here for *Resident*s and their substitute decision makers. Vaccination status of the *Residents* should not preclude them from leaving the *Home*, unless this is prescribed in a *State/Territory Health*

Directive, noting that appropriate and proportionate screening protocols may be put in place on their return to the *Home*.

Aged care service providers (providers) and *Visitors* to residential aged care homes (a *Home*) must in the first instance comply with their local *State/Territory Health Directive,* where they supersede the *Escalation Tiers* used in this document. The Code notes these *State/Territory Health Directives* and advice from AHPPC are listed at the conclusion of the Code. The Code recognises there are differences between the *State/Territory Health Directives* but seeks to set a national standard for visitation in aged care. The endorsing organisations of the Code continue to affirm the important role of *Partners-in-Care*[1] and the need for *State/Territory Health Directives* to provide particular considerations for this type of volunteers in any future updates to their Directives.

The Code notes the important role of volunteers in *Homes* and that *Partners-in-Care* may be considered 'a volunteer engaged by a *Home',* for the purposes of accessing COVID-19 vaccination and reporting of COVID-19 vaccination levels by the *Home*. However, *Partners-in-Care* should not be restricted entry unless this is a requirement of a *State/Territory Health Directive.*

The Code notes regular in-reach *Workers* such as representatives of the Community Visitors Scheme (CVS), Aged Care Quality and Safety Commission and National Aged Care Advocacy Program are not the responsibility of the provider for the purpose of ensuring vaccinations or reporting vaccination status, but would be subject to the same Screening Procedures as other people entering a *Home*. *Homes* may require *Visitors* to provide evidence of influenza vaccination each influenza season. Once screening procedures have been completed, and if there are no contraindications to entry highlighted from the screening process, *Homes* should not prevent access to these groups.

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 aged care home (a *Home*).

RIGHTS AND RESPONSIBILITIES

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 and/or *State/Territory Health Directives*.
- 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

***Residents* and Visitors**

- *Residents* have rights outlined in the Charter of Rights and Responsibilities
- *Residents* receive *Visitors* who access aged care *Homes* in accordance with the *Home*'s entry requirements (and/or in accordance with *State/Territory Health Directives*) and with the maximum frequency and length possible.
- To receive timely and regular updates and information, in appropriate formats, about government and health requirement as well as what is happening in the *Home*, consistent across the whole *Resident* population, and with

[1] *Partners-in-Care* are a particular type of Visitor outlined in Principle 7 of this Code and in line with the ACQSC advice.

require it, and usage of such circumstances will be closely monitored.

increased frequency of communication about local COVID-19 prevalence and transmission risk.
- To maintain contact with their local community outside the *Home*, including to participate in religious, social and cultural gatherings via alternate means such as online or phone.
- To be provided with *additional ways to connect* that they are able to participate in 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 in a COVID safe manner.
- To transfer to other accommodation or an alternate *Home*, following clarification of any *State/Territory Health Directive*, with regards to *Residents* wishes and consideration of support needs.

RESPONSIBILITIES

Providers

- Appropriately support *Workers* 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 representatives of *Resident*s (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, in appropriate formats. Proactive communication to occur to *Residents* and families where an outbreak occurs, delivered consistently across the *Resident* population.
- To ensure all *Workers* are vaccinated (where required) under *State/Territory Health Directives* and Australian Government Guidelines.

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 Workers*.
- To treat all *Workers* 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 prevention and control measures such as washing hands, use of visiting windows, remaining in *Resident*s' rooms, or in designated areas and Social Distancing and Hygiene Requirements – as directed by the aged care *Workers*.
- Comply with any *State/Territory Health Directives* (including compassionate ground exemptions for visiting where available).

- 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 Health Directives.
- Comply with *State/Territory Health Directives* (including compassionate ground exemptions for visiting where available).

PRINCIPLES

1. ***Right to visit*** **-** 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/Territory Health Directives*. *Visitors* include a *Resident's* family, families of choice and friends. 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* that should be permitted at all *Tier*s. While all volunteer types should be permitted during *Tier 1* and *Tier 2*, some *Homes* may decide not to permit other types of volunteers during *Tier 3*.

2. ***Types of visits*** **-** 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 *Workers* of the *Home*.

3. ***Density restrictions affecting visits*** **-** During periods of *Escalation Tier 2* or *Tier 3*, *Homes* may be required to limit the overall number of people in a *Home* 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 *Home*. In such circumstances the *Home* may preference *visits* by *Partners-in-Care* (as outlined in Principle 7 of the Code).

4. ***Resident preferences for visits*** **-** 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 Health Directives*. Visits between *Resident*s and their *Visitors* are to occur in a manner consistent with infection prevention and control measures including provisions relating to the use of designated areas for *visits* and the use of social distancing practices.

5. ***Legislative context for visits*** **-** 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 restrictive practices are used in accordance with the *Quality Care Principles*. The Code recognises that *Homes* must comply with the requirements of the *State/Territory 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 most recent influenza season[2], unless they provide evidence of a medical exemption from their treating medical practitioner.

6. ***Visitor responsibilities*** **-** At all three *Escalation Tier*s, no *Visitor* should attend a *Home* if they are unwell, have a temperature of greater than 37.5 degrees Celsius[3], 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 State/Territory 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[4]; and complying with *Visitor* requirements which include 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. Those with an accepted medical exemption in line *with State/Territory Health Directives* are allowed to enter the *Home*, noting proportionate infection prevention and control measures may be required.

7. ***Partners-in-Care*** **-** The Aged Care Quality and Safety Commission defines partnership in care[5] as an agreement between the *Resident*, a *Partner-in-Care* and the *Home*, where the *Partner-in-Care* may be involved in the delivery of services to, and the day-to-day care of, a *Resident*. This approach recognises an existing relationship between the *Resident* and their *Partner-in-Care* (for example a family member, loved one, friend or representative). A *Home* may also recognise a *Partner-in-Care* as a volunteer.

   A casual or regular *Visitor* not providing a specific aspect of care is not a *Partner-in-Care*. A *Partner-in-Care* helps maintain the wellbeing and quality of life of the *Resident*, as well as maintaining the important routines of the older person in care, especially where the older person has a cognitive impairment.

   They also assist to minimise the psycho-social impacts associated with COVID-19 related *Visitor* restrictions.

   Subject to Principle 6, a *Partner-in-Care* must be allowed access in the following circumstances:

   a) *Resident*s who are dying should be allowed *in-room visits* from loved ones and *Partners-in-Care* 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) *Resident*s who have a clearly established and regular pattern of involvement from *Partners-in-Care*. The kinds of care and support which can be provided by a *Partner-in-Care* are outlined in Partnerships in care, Supporting older people's wellbeing in residential care produced by the Aged Care Quality and Safety Commission.

   c) *Resident*s with a diagnosed mental health issue or at risk of mental health or psychological impacts associated with COVID-19 related *Visitor* restrictions (for example loneliness, anxiety, boredom, fear and depression) must be provided support including receiving regular *visits* from their *Partner-in-Care*. During *Escalation Tier 2*, consideration should be given for more flexible approaches for

[2] At 19 July 2021, Victoria, Tasmania and the Australian Capital Territory did not require people who wish to enter an aged care home to be vaccinated against influenza.
[3] SA direction is 38.0 degrees
[4] At 19 July 2021, Victoria, Tasmania and the Australian Capital Territory did not require people who wish to enter an aged care home to be vaccinated against influenza.
[5] In some State or Territory Health Directives these people are referred to as providing Essential Care.

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.

8. ***Visitor arrangements and screening*** **-** 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 including evenings and weekends where a *Home* is able to manage after hours V*isits*. *Resident*s, *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.

9. ***Deliveries to residents*** **-** At all three *Escalation Tier*s, *Resident*s 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 *Home*. The *Home* may require these deliveries to be made known to the *Home's Workers* 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.

10. ***Communications during restrictions*** **-** 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, in appropriate formats 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 timely assistance to use these, to enable *Resident*s to remain in touch with their loved ones.

11. ***Resident movements during restrictions*** **-** During *Escalation Tier 1* or *Tier 2*, *Resident*s 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*.

12. ***Resident access to medical and relates services*** **-** 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*. Vaccination status of the *Resident*s should not preclude them from leaving, noting that appropriate and proportionate screening protocols may be put in place. On return to the *Home* 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.

13. ***Resident outings*** **-** During *Escalation Tier 1* or *Tier 2* periods of preparedness escalation external outings and *Visits* are permitted for *Resident*s and Visitors where these can be conducted in a safe manner, noting these may not be permitted during *Escalation Tier 3*. Vaccination status of the *Resident*s should not preclude them from leaving, noting that appropriate and proportionate screening protocols may be put in place on their return to the *Home*. This means that there are appropriate infection prevention and control 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 to the *Home*. Providers will provide *Resident*s, 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 *Resident*s, families and representatives to document their agreement and compliance with this procedure.

14. ***Provider variations*** **-** 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 Health 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/Territory Health Directives.*

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.	• Consider your rights during COVID-19 Restrictions – see factsheet from the 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 an OPAN Service Delivery Organisation in your state or territory 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 the local OPAN Service Delivery Organisation. • If you believe the request from the local OPAN Service Delivery Organisation 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 *Home*, or may with your permission contact the *Home* to advocate on your behalf to be able to *Visit*. • OPAN can also assist *Resident*s 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 *Resident*s may be made via a window. During an outbreak of COVID-19 in the *Home*, or a local cluster in the surrounding suburbs or towns, window contacts may become a primary form of contact between *Resident*s 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 *Visit*s 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 is one of the three following considerations:

- **Any area where**: There is the occurrence of a case of infection in the community with a more transmissible variant of SARS-CoV-2 and opportunities for wide community exposure.
- **In a metropolitan area where**: The rolling 3 day average (average over 3 days) is 10 locally acquired cases per day. This equates to over 30 cases in 3 consecutive days.
- **A rural or regional area where**: The rolling 3 day average (average over 3 days) is 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 *Resident*s and *Visitor/s* are to occur during the COVID pandemic. Designated areas are put in place to allow for safe interactions between *Resident*s and *Visitors* that minimise the risk of infection and that allow for social distancing requirements. These areas will be particularly important for *Resident*s living in shared rooms, or where an individual *Resident* indicates, they do not wish to receive *Visitors* in their room.

Home – A location in which accommodation, and personal care or nursing care or both, are provided to a person in respect of whom a residential care subsidy or a flexible care subsidy is payable under the *Aged Care Act 1997*; the aged care portion of a funded Multi-purpose Service Program (MPS) and/or the part of a hospital providing State funded residential aged care.

Escalation Tiers – means Tier 1, Tier 2 or Tier 3 as articulated in Table 1 of the Visitation Guidelines for residential Aged Care Facilities endorsed by AHPPC.

Local Cluster –AHPPC recommends that *Homes* 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 *Home*. 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 as defined by the Aged Care Act 1997. 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 *Partners-in-Care* 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/Territory Health Directives –Refer to all State or Territory Emergency and Health Directives as relevant to aged care – the key documents of which are listed at the end of the Code. These government Directives are legally binding on aged care providers and individuals. Some states require *Visitors* to provide proof of immunisation for the current influenza season to be allowed entry.[6]

Partners-in-Care[7] – *Partners-in-Care* are a particular type of *Visitor* outlined in Principle 7 of this Code.

Physical Distancing and Hygiene Requirements – The general physical distancing requirement is 1.5m between people, practice hand hygiene (i.e. wash hands with soap or hand sanitiser for a minimum of 20 seconds) and ensure appropriate cough etiquette (for example coughing or sneezing into your elbow not hands). However, each State/Territory specifies the number of square metres that determines the maximum number of people in the building at any one time[8] (including *Resident*s, *Workers* and *Visitors*) and which may be different based on building size. The *Home* should clearly identify (for example at the point of entry or at reception) the maximum number of people that may be in the *Home* at any one time.

Surrounding suburbs or town / local vicinity – AHPPC recommends that *Homes* 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 *Home*. A guide would be that there is community transmission in the surrounding suburbs or town.

Visitor/s – *Visitors* include any person a *Resident* chooses to see including their family, family of choice, friends, their personal religious or spiritual advisors, legal representatives, *Partners-in-Care*, or Community Visitors Scheme volunteers. This is consistent of Table 1 of the AHHPC advice [INSERT LINK]. It is not up to the *Home* or its *Workers* 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*.

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 *Partners-in-Care* and people with dementia, and the situations covered by Principle 7 of this Code may be given in regard to designated visiting areas. Where

[6] At 19 July 2021, Victoria, Tasmania and the Australian Capital Territory did not require people who wish to enter an aged care home to be vaccinated against influenza.
[7] Some State or Territory Directives refer to 'Partners in care' as an 'Essential Care' Visitor.
[8] NSW aged care homes are exempt from the 4 square metre rule.

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 I*n-Person Visits* such as a designated visiting area that it shared between other *Resident*s. 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 Visits* 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 – *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.

Worker/s – Workers are defined in Table 1 in the AHPPC's Workforce scope for mandatory COVID-19 vaccination requirements. In line with the scope of the workforce outlined by the AHPPC advice on Vaccinations, individual *State/Territory Health Directives* will define who they are for the purposes of vaccinations (including any mandatory requirements) and entry. Some categories of Workers, as defined by AHPPC or *State/Territory Health Directives*, may not be employees/contractors of the *Home*. *The Home* is not responsible for having them vaccinated, but may require evidence of their vaccination to comply with the *Home's* practices including their infection prevention and control measures.

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 *Homes*.

This industry Code will be adopted during the period of COVID-19, after which usual practices will return. During the time limited period of 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 a *Home* begins to progressively return to pre-COVID-19 activities, it is important that older Australians generally and *Homes* 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 a *Home* over the longer term.

Human rights recognise that all people living in a *Home* have the right to freedom of movement and association, including the right for *Resident*s 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 *Resident*s. As outlined in the Charter of Aged Care Rights the rights of one *Resident* "*may compete with the rights of other consumers, family members or staff. When this occurs, the consumer and the service provider need to communicate openly and honestly about these competing rights and work together to come to a solution."* 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. *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 *Resident*s 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.

The continued risk of COVID-19 entering a *Home* remains a risk that needs to be managed to ensure the physical and emotional wellbeing of all *Resident*s. 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 *Home's* screening procedures. A *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 Health Directives* (or other State/Territory public health advice), from the Aged Care Response Centre within the relevant State/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 Tiers should be based on public health unit advice, *State/Territory Health Directive*, 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 *Home*.

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

Escalation Tiers (Tier 1, Tier 2, Tier 3)

The Code refers to *Escalation Tier*s as articulated in Table 1 of the Visitation Guidelines for Residential Aged Care Facilities endorsed by AHPPC. 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.

Examples of provider actions for visitation and external *Visits* by *Residents* using Escalation Tiers

The Visitation Guidelines for Residential Aged Care Facilities endorsed by AHPPC 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 of the Visitation Guidelines for Residential Aged Care Facilities endorsed by AHPPC 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 *Workers* 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, a suburb 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 *Workers* 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: State or territory emergency or health directives

Where the State or Territory Health Directive requires a *Home* 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.

Example 5: Uncertain community transmission of new variant strains

When a new variant emerges and there is likely but unconfirmed community transmission, or there is a significant community transmission of any variant, a provider may move to *Tier 2 or 3* sooner than otherwise might be expected until greater certainty is known about whether there is localised community transmission. During this time, it is important they consider *Visitor* restrictions in line with the Industry Code for Visiting Residential Aged Care *Home*s during COVID-19, particularly *Partners-in-Care* (as outlined in Principle 7 in relation to *Resident*s 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 6: Extended community lockdowns

Extended lockdowns negatively impact the mental health and wellbeing of *Resident*s. Particular attention should be paid to monitoring a *Resident*'s mental health and the need to establish new *Partners-in-Care* for high-risk *Resident*s. In cases of extended lockdown individuals required to assist in fulfilling mental health needs are not required to meet the usual *Partner-in-Care* criteria (i.e. they do not need to have been regularly involved in the care of the *Resident*). In these cases the provider should work with the *Partner-in-Care* to manage the mental health risks whilst still complying with community lockdown expectations. For example, the provider arranges regular *additional ways to connect* (e.g. 'window visits') between the *Partner-in-Care* and the *Resident*.

Where extended lockdowns at a *Home* or in the community are likely to occur (e.g. greater than 2 weeks) *additional ways to connect* (e.g. window visits) should be allowed to occur and considered as 'compassionate and essential care delivery' under stay at home orders (unless specifically banned by a State/Territory Health Directive). Principle 7 restricted visitations should continue to be facilitated.

LINKS TO KEY ADVICE AND DIRECTIVES

As at 5 August 2021 the following advice was available:

AUSTRALIAN GOVERNMENT ADVICE

Advice	Date Issued
Visitation Guidelines for Residential Aged Care Facilities	February 2021
AHPPC update to residential aged care facilities about minimising the impact of COVID-19	19 June 2020
AHPPC advice on residential aged care facilities	22 April 2020
ACQSC's Partnerships in Care Factsheet	1 July 2021
ACQSC's COVID-19 restrictions in residential aged care – your rights	9 July 2021
AHPPC advice on Mandatory Vaccination of Aged Care Workers	3 August 2021

STATE AND TERRITORY DIRECTIVES AND ADVICE

Jurisdiction	Name	Date Issued
Australian Capital Territory	Public Health (residential Aged Care Facilities) Emergency Direction 2021 (No 4)	8 June 2021
New South Wales	Public Health (COVID-19 Temporary Movement and Gathering Restrictions) Order 2021 Public Health (COVID-19 Gathering Restrictions) Order (No 2) 2021 *Additional advice from NSW Health is here.*	30 July 2021 7 July 2021
Northern Territory	COVID-19 Directions (No. 33) 2021: Directions for Aged Care Facilities	9 July 2021
Queensland	Residential Aged Care Direction (No.3)	23 July 2021
South Australia	Emergency Management (Residential Aged Care Facilities No 39) (COVID-19) Direction 2021	16 July 2021
Tasmania	Direction No. 12 for Residential Aged Care Facilities	31 July 2021
Victoria	Care Facilities Directions (No 39) *Additional advice from Victorian Department of Health is available for aged care providers and for visiting care homes.*	29 July 2021
Western Australia	Visitors to Residential Aged Care Facilities Directions (No.7)	24 February 2021

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